Voluntary Data Sharing Agreement

USER GUIDE

Version Effective Date:
December 1, 2005

NOTICE

On March 31, 2006, CMS will terminate all VDSAs executed prior to August 5, 2005. VDSA partners that are still submitting data under the old VDSA process, in use prior to August 5, 2005, must execute a new VDSA with CMS if they want to continue VDSA data exchange with CMS beyond March 31, 2006.

CMS expects all VDSA partners that executed their original VDSA with CMS prior to August 5, 2005 to sign the latest version of the new VDSA, which was first released on August 5, 2005, and to begin submitting input files in the new formats (contained in this User Guide) by March 31, 2006. To download a copy of the new Employer or Insurer VDSA, go to www.cms.hhs.gov/medicare/cob/vdsa

If you have questions or comments regarding this Notice, please contact any member of the CMS VDSA Operations Team. The Team members are listed on Page 15 of the new VDSA found at the internet address shown above.

INTRODUCTON

This Voluntary Data Sharing Agreement (VDSA) USER GUIDE provides information and instructions VDSA partners will find useful as they manage the VDSA data sharing process with the Centers for Medicare & Medicaid Services (CMS). In particular, a VDSA and the information in this document will allow users to coordinate Medicare Part D drug benefits with CMS under the terms of the Medicare Modernization Act (MMA).

FROM TIME TO TIME THE INFORMATION PROVIDED IN THIS USER GUIDE WILL CHANGE. As current requirements are refined and new processes developed, CMS will add new and revised material to this Guide. Existing and potential VDSA partners will then be notified that a new version is available on the CMS VDSA Web site, www.cms.hhs.gov/medicare/cob/vdsa/default.asp . VDSA partners must replace old versions of this Guide whenever CMS makes a new version available.

This VDSA User Guide assumes a fairly comprehensive understanding of the current VDSA process. Please contact us if you find material that is unclear or not helpful. All official CMS documentation regarding the VDSA process, including up-to-date record layouts and other information (such as Frequently Asked Questions) may also be

obtained from the Coordination of Benefits Contractor (COBC). Its email address is – COBVA@GHImedicare.com ; its main phone number is 646-458-6740.

If you have not yet signed a VDSA with CMS and would like more general information about the current VDSA process, please e-mail COBVA@GHImedicare.com and william.decker@cms.hhs.gov. Remember to provide us with the e-mail, phone number, and other contact information for individuals you would like to have added to our distribution list.

RECENT CHANGES: Updates to the User Guide

See the NOTICE, above. No major substantive changes have been made in this version of the User Guide. The record layouts and business rules remain the same. We have continued to edit the text for clarity, and in this update we have clarified the reporting for Health Reimbursement Accounts, Coverage Type Z, throughout.

SECTION A: COMPLETING AND SIGNING A VDSA

To make the VDSA relationship operational, the Voluntary Data Sharing partner and CMS have to sign and exchange completed copies of the VDSA. These are the instructions for completing a VDSA for signature.

1. In the first paragraph of the VDSA, insert all of your specific identifying information where indicated. The latest date that both the partner and CMS complete the signature process will be entered here, and will be the "Effective Date." If you wish, the date you enter may be prospective or retroactive. For example, some VDSA partners prefer to enter the first day of the month in which they expect the VDSA to be signed. But bear in mind that if you enter a prospective date, CMS cannot begin full implementation of the VDSA until we reach it.

2. Enter the date that is requested on Page 5 of the VDSA, in Section C, 1. This is the starting date for health plan enrollment information that is entered on the first regular production MSP Input File you provide to CMS.

We normally advise VDSA partners to submit historical enrollment data on their first production MSP Input File. We recommend that the data entered here cover a period starting no later than January 1 of the first full year prior to the execution of the Agreement. Thus, if the effective date of the VDSA is September 1, 2006 (for example), the first MSP Input File should include information dating back to at least January 1, 2005. This permits CMS and our partners to fill in gaps in enrollment information involving coordination of benefits that have not been found through other information exchange activities, such as the IRS/SSA/CMS Data Match questionnaires employers receive each year.

NOTE TO EMPLOYERS: Providing historical enrollment data covering a period starting no later than January 1 of the first complete year prior to the execution of the Agreement will allow CMS to immediately suppress mailings of all future IRS/SSA/CMS Data Match questionnaires. Because the IRS/SSA/CMS Data Match for any given year is based on information that is almost two years old when we receive it, without the historical data we suggest you provide us, employers will continue to be required to complete questionnaires until the IRS/SSA/CMS Data Match catches up to the end of the current tax year, which will take about two years.

3. On Page 14, in Section N, enter the partner's Administrative and Technical contact information.

4. Page 15, Section O: Upon receipt of a VDSA signed by the partner, CMS will provide the required Technical contact information. This does not need to be completed to execute the Agreement.

5. In the footer starting on Page 1, and throughout the rest of the document, insert the partner's business name.

The VDSA signature package consists of two documents: The VDSA itself, and the VDSA Implementation Questionnaire. The VDSA Implementation Questionnaire is used to assure both the VDSA partner and CMS that agreement on essential operational questions has been reached. VDSA partners must complete and return a copy of the VDSA Implementation Questionnaire to CMS with their signed VDSA. An Employer or Insurer version of the Questionnaire is included as part of the original package of material accompanying a VDSA to be signed and returned to CMS.

The VDSA partner will return two signed copies of the VDSA and one completed copy of the Implementation Questionnaire to CMS. One copy of the VDSA will be signed by CMS and returned to the partner. If it wishes, the partner can ask that CMS sign the VDSA first. CMS will then provide two signed copies of the VDSA to the partner, and the partner will sign one copy and return it to CMS. But in either case CMS will not consider the VDSA to be in force until the partner has also provided CMS with a completed copy of the Implementation Questionnaire.

To avoid unnecessary processing delays, we strongly recommend that you use an overnight delivery service, and send your VDSA(s) and Implementation Questionnaire to:

John Albert
Centers for Medicare and Medicaid Services
Office of Financial Management
Financial Services Group
Division of Medicare Secondary Payer Policy and Operations
Mail Stop: C3-14-16
7500 Security Boulevard
Baltimore, Maryland 21244-1850

SECTION B: THE VDSA DATA FILES – Standard Reporting Information

Standard Data Files: The data exchanged through the VDSA process is arranged in six different file schematics (also referred to as record layouts). A VDSA partner electronically transmits a data file to CMS. CMS processes the data in this *input file*, and at a prescribed time electronically transmits a *response file* to the partner. In a very few instances (as part of the retiree drug subsidy [RDS] file exchange process, for example) CMS will transmit a record layout to a partner without having first received a specific input file, but these are rare exceptions. In ordinary circumstances it will be an input file that will generate a response file.

Additional Data File: The VDSA program also requires one additional data set from the CMS partners. It is a *TIN* (Tax Identification Number) *Reference File*. This file consists of all business TIN's linked to the health insurance business operations of a VDSA partner.

Current versions of the six Standard Data Files and the TIN Reference File immediately follow. The Business Rules that apply to these Data Files can be found in Section III.

Once again we remind you that from time to time the information provided here will change. All significant updates to the material in the most recent version of this User Guide are listed on Page 1. Always check the Effective Date shown on Page 1 and in the footer on each page to be sure you are using the most recent version.

I. The Input and Response File Data Layouts

A – *The MSP* (Medicare Secondary Payer) *Input File*. This is the data set transmitted from a VDSA partner to CMS that is used to report information regarding Active Covered Individuals – people who are currently working (not carried as retired), and a spouse and (or) other dependents, and who are enrolled in and covered by an employer group health plan (GHP). At a minimum, we require the partner to include information about all Active Covered Individuals who are at least 55 years of age, and older. We have found that about ninety-seven percent of all Medicare beneficiaries are 55 and above.

Employer/Insurer Voluntary MSP Input File Layout – 425 bytes					
Field	**Name**	**Size**	**Displacement**	**Data Type**	**Description**
1.	HIC Number	12	1-12	Alpha-Numeric	Beneficiary's Health Insurance Claim Number. Required if SSN not provided. Populate with spaces if unavailable.
2.	Beneficiary Surname	6	13-18	Text	Beneficiary's Last Name – Required.
3.	Beneficiary First Initial	1	19-19	Alpha	Beneficiary's First Initial – Required.
4.	Beneficiary Date of Birth	8	20-27	Date	Beneficiary's DOB (CCYYMMDD) – Required.
5.	Beneficiary Sex Code	1	28-28	Numeric	Beneficiary's Sex – Required. Valid Values: 0 = Unknown 1 = Male 2 = Female
6.	DCN	15	29-43	Text	Document Control Number; assigned by the VDSA partner. Required. Each record shall have a unique DCN.
7.	Transaction Type	1	44-44	Numeric	Type of Maintenance – Required. Valid Values: '0' = Add Record '1' = Delete record '2' = Update record
8.	Coverage Type	1	45-45	Alpha-Numeric	Type of Insurance – Required. Valid Values: 'J' = Hospital Only 'K' = Medical Only 'A' = Hospital and Medical 'U' = Drug Only (network Rx) 'V' = Drug with Major Medical

Employer/Insurer Voluntary MSP Input File Layout – 425 bytes					
Field	**Name**	**Size**	**Displacement**	**Data Type**	**Description**
					(non-network Rx) 'W' = Comprehensive Coverage - Hosp/Med/Drug (network Rx) 'X' = Hospital and Drug (network Rx) 'Y' = Medical and Drug (network Rx) 'Z' = Health Reimbursement Account (non-network Rx) '4' = Comprehensive Coverage - Hosp/Med/Drug (non-network Rx) '5' = Hospital and Drug (non-network Rx) '6' = Medical and Drug (non-network Rx)
9.	Beneficiary Social Security number	9	46-54	Numeric	Beneficiary's SSN – Required if HICN not provided. Populate with 9 spaces if unavailable.
10.	Effective Date	8	55-62	Date	Start Date of Covered Individual's Primary Coverage by Insurer. (CCYYMMDD) – Required.
11.	Termination Date	8	63-70	Date	End Date of Covered Individual's Primary Coverage by Insurer. (CCYYMMDD) – Required. *Use all zeros if open-ended.
12.	Relationship Code	2	71-72	Numeric	Covered Individual's Relation to Policy Holder – Required. Valid values: '01' = Covered Individual is Policy Holder '02' = Spouse '03' = Child '04' = Other

Employer/Insurer Voluntary MSP Input File Layout – 425 bytes					
Field	**Name**	**Size**	**Displacement**	**Data Type**	**Description**
13.	Policy Holder's First Name	9	73-81	Text	Policy Holder's First name – Required.
14.	Policy Holder's Last Name	16	82-97	Text	Policy Holder's Last Name – Required.
15.	Policy Holder's SSN	9	98-106	Numeric	Policy Holder's SSN – Required.
16.	Employer Size	1	107	Numeric	Valid Values: '0' = 1 to 19 employees** '1' = 20 to 99 employees** '2' = 100 or more employees Employer Size Rule: Enter '1' if employer has fewer than 20 employees but is part of a multi-employer plan where another employer in that plan has 20 or more employees. Required.
17.	Group Policy Number	20	108-127	Text	Policy Number Assigned by primary Payer - For use when coverage type is V, Z, 4, 5, and 6.
18.	Individual Policy Number	17	128-144	Text	Individual Policy Number - Required for Coverage types V, Z, 4, 5, and 6.
19.	Employee Coverage Election	1	145	Numeric	Who the Policy Covers – Required. '1' = Policyholder Only. '2' = Policyholder & Family. '3' = Policyholder & Dependents, but not Spouse.
20.	Employee Status	1	146	Numeric	'1' = Plan is primary because active employee is in current

Employer/Insurer Voluntary MSP Input File Layout – 425 bytes					
Field	**Name**	**Size**	**Displacement**	**Data Type**	**Description**
					employment status. '2' = Plan is primary for another reason (e.g., active employee is a retiree under age 65, but retains primary coverage through the employer because the Active Employee or covered dependent has ESRD (End-Stage Renal Disease). Required.
21.	Employer TIN	9	147-155	Numeric	Employer Tax Identification Number – Required.
22.	Insurer TIN	9	156-164	Numeric	Insurer Tax Identification Number – Required.
23.	National Health Plan	10	165-174	Filler	National Health Plan Identifier – (Future Use).
24.	Rx Insured ID number	20	175-194	Text	Insured's Identification Number. Required for coverage types U, W, X, & Y
25.	Rx Group Number	15	195-209	Text	Group Number For use when coverage type is V, Z, 4, 5, and 6.
26.	Rx PCN	10	210-219	Text	Processor Control Number
27.	Rx BIN Number	6	220-225	Text	International Identification Number. Required for coverage types U, W, X, & Y
28.	Rx Toll Free Number	18	226- 243	Text plus "(" and ")"	Toll Free Number.
29.	Person Code	3	244-246	Text	Person code the plan uses to identify specific individuals on a policy. Values are policy specific.
30.	Reserved	10	247-256	Alpha-Numeric	Reserved for COB use. Fill with spaces only.

Employer/Insurer Voluntary MSP Input File Layout – 425 bytes					
Field	**Name**	**Size**	**Displacement**	**Data Type**	**Description**
31.	Reserved	5	257-261	Alpha-Numeric	Reserved for COB use. Fill with spaces only.
32.	Filler	164	262-425	Alpha-Numeric	Unused Field. Fill with spaces only.
Header Record					
1.	Header Indicator	2	1-2	Alpha	Should be: 'H0'
2.	VDSA ID	4	3-6	Numeric	'0001', '0002', etc. ID number assigned by COBC. (Previously labeled as "Plan Number.")
3.	Contractor Number	5	7-11	Numeric	'11105' – Employer. '11106' – Insurer. '11112' – BCBS.
4.	File Type	4	12-15	Alpha	Valid values: 'REFR' – TIN reference file. 'MSPI' – MSP input file.
5.	File Date	8	16-23	Numeric Date	CCYYMMDD
6.	Filler	402	24-425	Alpha Numeric	Unused Field – fill with spaces.

Trailer Record					
1.	Trailer Indicator	2	1-2	Alpha	Should be: 'T0'
2.	VDSA ID	4	3-6	Numeric	'0001', '0002', etc. ID number assigned by COBC. (Previously labeled as "Plan Number.")
3.	Contractor Number	5	7-11	Numeric	'11105' – Employer. '11106' – Insurer. '11112' – BCBS.
4.	File Type	4	12-15	Alpha	'REFR' – TIN reference file. 'MSPI' – MSP input file.

5.	File Date	8	16-23	Numeric Date	CCYYMMDD
6.	Record Count	9	24-32	Numeric	Number of records on file.
7.	Filler	393	33-425	Alpha-Numeric	Unused Field – fill with spaces.

B – *The TIN Reference File*. The TIN Reference File consists of a business entity's federal TIN and the firm's business mailing address that is linked to the particular TIN. The same firm can have more than one TIN. For example, a company can operate both a Health Maintenance Organization (HMO) and a separate and distinct specialty medical center. Because they are separate business operations, each could have its own TIN, and each TIN may be associated with a distinct business mailing address. (Note: The TIN is the same as the federal Employer ID Number, the EIN.) The mailing address associated with each TIN should be the address to which health care insurance coordination of benefits issues should be directed. This mailing address will help CMS and others to direct correspondence to the most appropriate contact at the VDSA partner.

The VDSA partner's TIN Reference File should be comprised of all the TINs relevant to the partner's business as it relates to CMS. For example, an employer's TIN Reference File may consist of just the one employer and insurer TIN and associated business address of the employer and insurer that administers all aspects of the employer's health benefit coverage. But an insurer must provide complete TIN information about all its employer clients. We have placed the Tin Reference File here, following the MSP Input File, because links to TINs are most closely associated with MSP program requirements.

TIN Reference File Layout – 425 bytes					
Field	**Name**	**Size**	**Displacement**	**Data Type**	**Description**
1.	TIN	9	1-9	Numeric	Tax identification number of the entity, or cross-reference number to TIN field in the detail records. The TIN indicator field identifies which has been used.
2.	Name	32	10-41	Text	Name of the entity.
3.	Address Line 1	32	42-73	Text	Address Line 1.

4.	Address Line 2	32	74-105	Text	Address Line 2.
5.	City	15	106-120	Text	City.
6.	State	2	121-122	Alpha	State – Must be a valid USPS state abbreviation.
7.	Zip Code	9	123-131	Alpha-Numeric	Zip Code.
8.	TIN indicator	1	132	Alpha	Used to indicate whether the TIN is for an insurer or employer, or if a pseudo TIN number is contained in the TIN field. Values: E = The TIN field contains a valid TIN for an Employer. I = The TIN field contains a valid TIN for an Insurer. Y = Value contained in the TIN field is only to be used as a cross-reference to the address fields. The field does not contain an actual TIN.
9.	Filler	293	133-425	Text	Future use – Fill with spaces.

C – *The MSP Response File*. This is the data set transmitted from CMS to the VDSA partner after the information supplied in the partner's MSP Input File has been processed. It consists of the same data elements in the Input File, with corrections applied by CMS, disposition and edits codes which let you know what we did with the record, as well as new information for the partner regarding the covered individuals themselves, such as Medicare program coverage details and the like.

Employer/Insurer Voluntary MSP Response File Layout - 800 bytes				
Field	**Name**	**Size**	**Displacement**	**Description**
1.	Filler	4	1-4	For COBC internal use.
2.	HIC Number	12	5-16	Beneficiary Health Insurance Claim Number. Field will contain either the HICN matched or corrected HICN based on SSN match.
3.	Beneficiary Surname	6	17-22	Beneficiary's Last Name. Field will contain either the name supplied or corrected name from COB database.
4.	Beneficiary First Initial	1	23	Beneficiary's First Initial. Field will contain either the value supplied or corrected value from COB database.
5.	Beneficiary Date of Birth	8	24-31	Beneficiary's DOB. (CCYYMMDD) Field will contain either the value supplied or corrected value from COB database.
6.	Beneficiary Sex Code	1	32	Beneficiary's Sex: 0 = Unknown 1 = Male 2 = Female Field will contain either the value supplied or corrected value from COB database.
7.	COBC DCN	15	33-47	Document Control Number assigned by COBC.
8.	Disposition Code	2	48-49	Response Disposition Code from CWF.
9.	Transaction Type	1	50	Type of Maintenance: '0' = Add Record '1' = Delete record '2' = Update record Type of transaction applied by COB.

Employer/Insurer Voluntary MSP Response File Layout - 800 bytes				
Field	**Name**	**Size**	**Displacement**	**Description**
10.	Reason for Medicare Entitlement	1	51	Reason for Medicare Entitlement: 'A' = Working Aged 'B' = ESRD 'G' = Disabled Value returned if individual is entitled. COB Supplied.
11.	Coverage Type (insurer type/policy type)	1	52	Type of Insurance: 'J' = Hospital Only 'K' = Medical Only 'A' = Hospital and Medical 'U' = Drug Only (network Rx) 'V' = Drug with Major Medical (non-network Rx) 'W' = Comprehensive Coverage - Hosp/Med/Drug (network Rx) 'X' = Hospital and Drug (network Rx) 'Y' = Medical and Drug (network Rx) 'Z' = Health Reimbursement Account (non-network Rx) '4' = Comprehensive Coverage - Hosp/Med/Drug (non-network Rx) '5' = Hospital and Drug (non-network Rx) '6' = Medical and Drug (non-network Rx) Field will contain value supplied on input.
12.	Insurer Name	32	53-84	Insurer name. Field will contain value supplied on input.
13.	Insurer Address 1	32	85-116	Insurer's Address Line 1. Field will contain value supplied on input.
14.	Insurer Address 2	32	117-148	Insurer's Address Line 2. Field will contain value supplied on input.
15.	Insurer City	15	149-163	Insurer's City. Field will contain value supplied on input.

Employer/Insurer Voluntary MSP Response File Layout - 800 bytes				
Field	**Name**	**Size**	**Displacement**	**Description**
16.	Insurer State	2	164-165	Insurer's State. Field will contain value supplied on input.
17.	Insurer Zip Code	9	166-174	Insurer's Zip Code. Field will contain value supplied on input.
18.	Beneficiary SSN	9	175-183	Beneficiary's SSN. Field will contain either the SSN matched or corrected SSN based on HICN match.
19.	MSP Effective Date	8	184-191	Start Date of Beneficiary's Primary Coverage by Insurer (CCYYMMDD).
20.	MSP Termination Date	8	192-199	End Date of Beneficiary's Primary Coverage by Insurer (CCYYMMDD). *All zeros if open-ended.
21.	Relationship Code	2	200-201	Covered Individual's Relationship to Active Employee: '01' = Covered Individual is Active Employee '02' = Spouse '03' = Child '04' = Other Defaults to '01'
22.	Policy Holder's First Name	9	202-210	Active Employee's First Name.
23.	Policy Holder's Last Name	16	211-226	Active Employee's Last Name.
24.	Policy Holder's SSN	12	227-238	Active Employee's SSN. (9 digits, left justified.)
25.	Employer's Name	32	239-270	Employer Providing Coverage. Field will contain value supplied on TIN input.

Employer/Insurer Voluntary MSP Response File Layout - 800 bytes				
Field	**Name**	**Size**	**Displacement**	**Description**
26.	Employer's Address Line 1	32	271-302	Employer's Street Address line 1. Field will contain value supplied on TIN input.
27.	Employer's Address Line 2	32	303-334	Employer's Street Address line 2. Field will contain TIN input value.
28.	Employer's City	15	335-349	Employer's City. Field will contain value supplied on TIN input.
29.	Employer's State	2	350-351	Employer's State Code. Field will contain value supplied on TIN input.
30.	Employer's Zip Code	9	352-360	Employer's Zip Code. Field will contain value supplied on TIN input.
31.	Group Policy Number	20	361-380	Group Policy Number. Field will contain value supplied on input.
32.	Individual Policy Number	17	381-397	Individual's Policy Number. Field will contain value supplied on input.
33.	Last Query Date	8	398-405	Last Date Sent to CWF (Common Working File). (CCYYMMDD) COB supplied.
34.	Current Disposition Code	2	406-407	Result from Most Current CWF Transmission (same as Field #8). COB supplied.
35.	Current Disposition Date	8	408-415	Date of Most Current CWF Transmission. (CCYYMMDD) COB supplied.
36.	Previous Disposition Code	2	416-417	Result from Previous CWF Transmission. COB supplied.

Employer/Insurer Voluntary MSP Response File Layout - 800 bytes				
Field	**Name**	**Size**	**Displacement**	**Description**
37.	Previous Disposition Date	8	418-425	Date of Previous CWF Transmission. (CCYYMMDD) COB supplied.
38.	First Disposition Code	2	426-427	Result from First CWF Transmission. COB supplied.
39.	First Disposition Date	8	428-435	Date of First CWF Transmission. (CCYYMMDD) COB supplied.
40.	Error Code 1	4	436-439	SP Error Code 1 COB or CWF supplied.
41.	Error Code 2	4	440-443	SP Error Code 2 COB or CWF supplied.
42.	Error Code 3	4	444-447	SP Error Code 3 COB or CWF supplied.
43.	Error Code 4	4	448-451	SP Error Code 4 COB or CWF supplied.
44.	Split Entitlement Indicator	1	452	Entitlement Split Indicator: 'Y' = yes 'N' or blank = no COB supplied.
45.	Original Reason for Medicare Entitlement	1	453	Original Reason for Medicare Entitlement: 'A' = Working Aged 'B' = ESRD 'G' = Disabled COB supplied.
46.	Original Coverage Effective Date	8	454-461	The original coverage effective date sent. This gets populated if a SP31 error occurs. (MMDDCCYY) Field will be the value supplied on input.

Employer/Insurer Voluntary MSP Response File Layout - 800 bytes				
Field	**Name**	**Size**	**Displacement**	**Description**
47.	Original Coverage Termination Date	8	462-469	The original coverage termination date sent. This gets populated if a SP32 error occurs. (MMDDCCYY) *All zeros if open-ended. Field will be the value supplied on input.
48.	Partner Assigned DCN	15	470-484	The Document Control Number assigned by the VDSA partner. It is moved here so we can provide our own unique COBC DCN in Field 7. Field will be the value supplied on input.
49.	Current Medicare Part A Effective Date	8	485-492	Effective Date of Medicare Coverage. (CCYYMMDD) COB supplied.
50.	Current Medicare Part A Termination Date	8	493-500	Termination Date of Medicare Coverage. (CCYYMMDD) * All zeros if open-ended. COB supplied.
51.	Current Medicare Part B Effective Date	8	501-508	Effective Date of Medicare Coverage. (CCYYMMDD) COB supplied.
52.	Current Medicare Part B Termination Date	8	509-516	Termination Date of Medicare Coverage. (CCYYMMDD) * All zeros if open-ended. COB supplied.
53.	Medicare Beneficiary Date of Death	8	517-524	Medicare Beneficiary Date of Death. (CCYYMMDD) COB supplied.

Employer/Insurer Voluntary MSP Response File Layout - 800 bytes				
Field	**Name**	**Size**	**Displacement**	**Description**
54.	MA/MA-PD Contractor Number	5	525-529	Medicare Advantage/Medicare Advantage with Prescription Drug Contractor Number. COB supplied.
55.	MA/MA-PD Effective Date	8	530-537	Effective Date of Medicare Advantage/Medicare Advantage with Prescription Drug Coverage. (CCYYMMDD) COB supplied.
56.	MA/MA-PD Termination Date	8	538-545	Termination Date of Medicare Advantage/Medicare Advantage with Prescription Drug Coverage. (CCYYMMDD) * All zeros if open-ended. COB supplied.
57.	PDP Contractor Number	5	546-550	Prescription Drug Plan Contractor Number for use when beneficiary has MA with PDP covered by separate contractor. COB supplied.
58.	PDP Effective Date	8	551-558	Effective Date of Prescription Drug Plan Coverage (CCYYMMDD) for use when beneficiary has MA with PDP covered by separate contractor. COB supplied.
59.	PDP Termination Date	8	559-566	Termination Date of Prescription Drug Plan Coverage (CCYYMMDD) for use when beneficiary has MA with PDP covered by separate contractor. * All zeros if open-ended. COB supplied.
60.	Current Part D Effective Date	8	567-574	Effective Date of Medicare Part D Coverage. (CCYYMMDD) COB supplied.

Employer/Insurer Voluntary MSP Response File Layout - 800 bytes				
Field	**Name**	**Size**	**Displacement**	**Description**
61.	Current Part D Termination Date	8	575-582	Termination Date of Medicare Part D Coverage. (CCYYMMDD) * All zeros if open-ended. COB supplied.
62.	National Health Plan ID	10	583-592	National Health Plan Identifier. (Future requirement.) Field will contain value supplied on input.
63.	Rx Insured ID number	20	593-612	Insured's Identification Number. Field will contain value supplied on input.
64.	Rx Group Number	15	613-627	Group Number. Field will contain value supplied on input.
65.	Rx PCN	10	628-637	Processor Control Number. Field will contain value supplied on input.
66.	Rx BIN Number	6	638-643	International Identification Number. Field will contain value supplied on input.
67.	Rx 800 Number	18	644-661	Toll Free Number. Field will contain value supplied on input.
68.	Person Code	3	662-664	Person Code. Field will contain value supplied on input.
69.	Rx Disposition Code	2	665-666	Rx Result from BENEMSTR/MBD. MBD/COB supplied.
70.	Rx Disposition Date	8	667-674	Date - Rx Result from BENEMSTR/MBD. (CCYYMMDD) COB supplied.
71.	Rx Error Code 1	4	675-678	Rx Error Code 1. COB supplied.
72.	Rx Error Code 2	4	679-682	Rx Error Code 2. COB supplied.
73.	Rx Error Code 3	4	683-686	Rx Error Code 3. COB supplied.

Employer/Insurer Voluntary MSP Response File Layout - 800 bytes				
Field	**Name**	**Size**	**Displacement**	**Description**
74.	Rx Error Code 4	4	687-690	Rx Error Code 4. COB supplied.
75.	Filler	110	691-800	Unused Field. Space filled.
Header Record				
1.	Header Indicator	2	1-2	Should be: 'H0'
2.	VDSA ID	4	3-6	'0001', '0002', etc. ID number assigned by COBC. (Previously labeled as "Plan Number.") Field will contain value supplied on input.
3.	Contractor Number	5	7-11	'11105' – employer '11106' - insurer '11112' – BCBS Field will contain value supplied on input.
4.	File Type	4	12-15	'MSPR' – MSP input file.
5.	File Date	8	16-23	CCYYMMDD COB supplied.
6.	Filler	777	24-800	Unused Field. Space filled.
Trailer Record				
1.	Trailer Indicator	2	1-2	Should be: 'T0'
2.	VDSA ID	4	3-6	'0001', '0002', etc. ID number assigned by COBC. (previously labeled as "Plan Number") Field will contain value supplied on input.
3.	Contractor Number	5	7-11	'11105' – employer '11106' - insurer '11112' – BCBS Field will contain value supplied on input.
4.	File Type	4	12-15	'MSPR' – MSP input file.

Employer/Insurer Voluntary MSP Response File Layout - 800 bytes				
Field	**Name**	**Size**	**Displacement**	**Description**
5.	File Date	8	16-23	CCYYMMDD COB supplied.
6.	Record Count	9	24-32	Number of records on file. COB supplied.
7.	Filler	768	33-800	Unused Field – Space filled.

D – *The Non-MSP Input File*. This is the data set transmitted from a VDSA partner to CMS that is used to report information regarding the health insurance coverage information of a VDSA partner's Inactive Covered Individuals – people who are currently not working (most are carried as retired), and a spouse and (or) other dependents, and who are enrolled in a health plan or policy, including but not limited to a GHP or policy, for which the partner or a subsidiary acts as an employer, insurer, third party administrator, health plan sponsor or any combination thereof – and who cannot be classified as Active Covered Individuals. The Non-MSP Input File is used to report drug coverage information that is secondary to Medicare Part D. The Non-MSP Input File can also be used to query CMS about potential beneficiary Part D coverage and can be used as a way to submit enrollment files to the Retiree Drug Subsidy (RDS) Center for those employers claiming the Employer Drug Subsidy.

Voluntary Non-MSP Input File Layout – 300 bytes					
Field	**Name**	**Size**	**Displacement**	**Data type**	**Description**
1.	Beneficiary Social Security Number	9	1-9	Numeric	Covered Individual's Social Security Number. Required if HICN not populated. Use 9 digits, 0-9 Fill with spaces if SSN not available.

Voluntary Non-MSP Input File Layout – 300 bytes					
Field	**Name**	**Size**	**Displacement**	**Data type**	**Description**
2.	HIC Number	12	10-21	Alpha-Numeric	Covered Individual's Health Insurance Claim Number. Required if SSN not populated. Populate with spaces if not available.
3.	Covered Individual's Surname	6	22-27	Text	Covered Individual's Last Name – Required.
4.	Covered Individual's First Initial	1	28-28	Alpha	Covered Individual's First Initial – Required.
5.	Covered Individual's Middle Initial	1	29-29	Alpha	Covered Individual's Middle Initial – Optional.
6.	Covered Individual's Date of Birth	8	30-37	Numeric Date	Covered Individual's DOB. (CCYYMMDD). Required.
7.	Covered Individual's Sex Code	1	38-38	Numeric	Covered Individual's Sex – Valid values: 0 = Unknown 1 = Male 2 = Female Required.
8.	Group Health Plan (GHP) Number	20	39-58	Text	GHP Number assigned by Payer for action type D, or, Unique Benefit Option Identifier assigned by Payer for action type S. For use with Action Types D and S. Required for Action Type S when Coverage Type is V, Z, 4, 5 or 6.
9.	Individual Policy	17	59-75	Text	Unique Identifier assigned by the payer to identify the

Voluntary Non-MSP Input File Layout – 300 bytes					
Field	**Name**	**Size**	**Displacement**	**Data type**	**Description**
	Number				covered individual. For use with action types D and S. Required for action type D when coverage type is V, Z, 4, 5, and 6.
10.	Effective Date	8	76-83	Numeric Date	Start Date of Covered Individual's Primary Coverage by Insurer. (CCYYMMDD) Required for action types D and S.
11.	Termination Date	8	84-91	Numeric Date	End Date of Covered Individual's Primary Coverage by Insurer. (CCYYMMDD). **All zeros if open-ended. For use with action types D and S. Required for action type S.
12.	National Health Plan	10	92-101	Filler	National Health Plan Identifier. (Future Use.)
13.	Rx Insured ID number	20	102-121	Text	Insured's Identification Number. For use with action types D and S. Required for action type D when coverage type = U, W, X, or Y.
14.	Rx Group Number	15	122-136	Text	Rx Group Health Plan Number assigned by Payer for action type D, or, Unique Benefit Option Identifier assigned by Payer for action type S. For use with Action Types D and S. Required with Action Type S when coverage type = U, W, X, or Y.
15.	Rx PCN	10	137-146	Text	Processor Control Number for Medicare Beneficiaries.

Voluntary Non-MSP Input File Layout – 300 bytes					
Field	**Name**	**Size**	**Displacement**	**Data type**	**Description**
					For use with action type D and S when coverage type = U, W, X, or Y.
16.	Rx BIN Number	6	147-152	Text	International Identification Number for Medicare Beneficiaries. For use with action types D and S. Required for action type D when coverage type = U, W, X, or Y.
17.	Rx Toll Free Number	18	153-170	Text plus "(" and ")"	Toll Free Number.
18.	Relationship Code	2	171-172	Numeric	Covered Individual's Relation to Policy Holder: Valid values: '01' = Covered Individual is Policy Holder '02' = Spouse '03' = Child '04' = Other Or spaces. Required for action types D and S.
19.	Partner Assigned DCN	15	173-187	Text	Document Control Number; assigned by the VDSA partner. Required. Each record shall have a unique DCN.
20.	Action Type	1	188	Alpha	Type of Maintenance: Valid values: 'D' = Drug Reporting record 'S' = Subsidy Reporting record 'N' = Non-Reporting record Required.

Voluntary Non-MSP Input File Layout – 300 bytes					
Field	**Name**	**Size**	**Displacement**	**Data type**	**Description**
21	Transaction Type	1	189	Numeric	Type of Maintenance: Valid values: '0' = Add Record '1' = Delete record '2' = Update record Or space. Required for action type D or S.
22.	Coverage Type	1	190	Alpha-Numeric	Type of Coverage: 'U' - Drug Only (network Rx) 'V' - Drug with Major Medical (non-network Rx) 'W' - Comprehensive Coverage - Hosp/Med/Drug (network Rx) 'X' - Hospital and Drug (network Rx) 'Y' – Medical and Drug (network Rx) 'Z' – Health Reimbursement Account (non-network Rx) '4' = Comprehensive Coverage -Hosp/Med/Drug (non-network Rx) '5' = Hospital and Drug (non-network Rx) '6' = Medical and Drug (non-network Rx). Required for action type D or S.
23.	Person Code	3	191-193	Text	Person code the plan uses to identify specific individuals on a policy. For use with action types D and S.

Voluntary Non-MSP Input File Layout – 300 bytes					
Field	**Name**	**Size**	**Displacement**	**Data type**	**Description**
24.	Reserved	10	194-203	Internal use	Reserved for COB internal use; Fill with spaces only
25.	Reserved	5	204-208	Internal use	Reserved for COB internal use; Fill with spaces only
26.	Reserved	1	209	Internal use	Reserved for COB internal use; Space fill only
27.	Filler	91	210-300	Filler	Unused Field.
Header Record					
1.	Header Indicator	2	1-2	Alpha	Should be: 'H0'
2.	VDSA ID	4	3-6	Numeric	'0001', '0002', etc. ID number assigned by COBC. (Previously labeled as "Plan Number.")
3.	Contractor Number	5	7-11	Numeric	'11105' employer '11106' – insurer '11112' – BCBS
4.	File Type	4	12-15	Alpha	'NMSI' – non-MSP input file.
5.	File Date	8	16-23	Numeric	CCYYMMDD
6.	RDS Application Number	10	24-33	Alpha-Numeric	Retiree Drug Subsidy ID number assigned by the RDS Contractor that is associated with a particular RDS application. When populated this field should contain 10 digits (0-9), right justified with leading positions zero filled. This application number will change each year when a new application is submitted. Required for files containing action type S. Fill with spaces for Action Types D and N.
7.	Filler	267	34-300	Filler	Unused Field.

Voluntary Non-MSP Input File Layout – 300 bytes					
Field	**Name**	**Size**	**Displacement**	**Data type**	**Description**
Trailer Record					
1.	Trailer Indicator	2	1-2	Alpha	Should be: 'T0'
2.	VDSA ID	4	3-6	Numeric	'0001', '0002', etc. ID number assigned by COBC (previously labeled as "Plan Number").
3.	Contractor Number	5	7-11	Numeric	'11105'- employer '11106' – insurer '11112' – BCBS
4.	File Type	4	12-15	Alpha	'NMSI' – non-MSP input file.
5.	File Date	8	16-23	Numeric	CCYYMMDD
6.	S Record Count	9	24-32	Numeric	Number of Action type 'S' records on file.
7.	D Record Count	9	33-41	Numeric	Number of Action type 'D' records on file.
8.	N Record Count	9	42-50	Numeric	Number of Action type 'N' records on file.
9.	Total Record Count	9	51-59	Numeric	Total of all records on file.
10.	Filler	241	60-300	Filler	Unused Field.

E – *The Non-MSP Response File*. This is the data set transmitted from CMS to the VDSA partner after the information supplied in the partner's Non-MSP Input File has been processed. It consists of the same data elements in the Input File, with corrections applied by CMS, disposition and edits codes which let you know what we did with the record, as well as new information for the partner regarding the covered individuals themselves, such as Medicare program coverage details and the like.

VDSA Non-MSP Response File Layout - 500 bytes				
Field	**Name**	**Size**	**Displacement**	**Description**
1.	Filler	4	1-4	COBC use
2.	SSN	9	5-13	Beneficiary's SSN. Included for action types D, S, and N. Field will contain either the SSN matched, or a corrected SSN based on a HICN match.
3.	HIC Number	12	14-25	Beneficiary's Health Insurance Claim Number. Included for action types D, S, and N. Field will contain either the HICN matched, or a corrected HICN based on a SSN match.
4.	Covered Individual's Surname	6	26-31	Beneficiary's Last Name. Included for action types D, S, and N. Field will contain either the name supplied or corrected name from COB database.
5.	Beneficiary First Initial	1	32	Beneficiary's First Initial. Included for action types D, S, and N. Field will contain either the value supplied or corrected value from COB database.
6.	Beneficiary Middle Initial	1	33	Beneficiary's Middle Initial. Included for action types D, S, and N. Field will contain either the value supplied.
7.	Beneficiary Date of Birth	8	34-41	Beneficiary's DOB (CCYYMMDD). Included for action types D, S, and N. Field will contain either the value supplied or corrected value from COB database.
8.	Beneficiary Sex Code	1	42	Beneficiary's Sex: 0 = Unknown 1 = Male 2 = Female Included for action types D, S, and N Field will contain either the value supplied or corrected value from COB database.

VDSA Non-MSP Response File Layout - 500 bytes				
Field	**Name**	**Size**	**Displacement**	**Description**
9.	Group Health Plan Number	20	43-62	GHP Number assigned by Payer for action type 'D,' or, Unique Benefit Option Identifier assigned by Payer for action type 'S.' Included for action types D and S. Field will contain value supplied on input.
10.	Individual Policy number	17	63-79	Policy Number. Included for action types D and S. Field will contain value supplied on input.
11.	Effective Date	8	80-87	Start Date of Beneficiary's Insurance Coverage. (CCYYMMDD). Included for action types D and S. Field will contain the effective date applied to the CWF and/or Drug record.
12.	Termination Date	8	88-95	End Date of Beneficiary's Insurance Coverage. (CCYYMMDD) **All zeros if open-ended or non-applicable. Included for action types D and S. Field will contain the term date applied to the CWF and/or Drug record.
13.	National Health Plan ID	10	96-105	National Health Plan Identifier. For action types D and S. (Future Use).
14.	Rx Insured ID number	20	106-125	Insured's Identification Number. Included for action types D and S. Field will contain value supplied on input.
15.	Rx Group Number	15	126-140	Rx Group Health Plan Number assigned by payer for action type 'D,' or Unique Benefit Option Identifier assigned by payer for action type 'S.' Included for action types D and S. Field will contain value supplied on input.
16.	Rx PCN	10	141-150	Processor Control Number. Included for action types D and S. Field will contain value supplied on input.

VDSA Non-MSP Response File Layout - 500 bytes				
Field	**Name**	**Size**	**Displacement**	**Description**
17.	Rx BIN Number	6	151-156	International Identification Number. Included for action types D and S. Field will contain value supplied on input.
18.	Rx Toll Free Number	18	157-174	Toll Free Number with extension. Included for action types D and S. Field will contain value supplied on input.
19.	Person Code	3	175-177	Person Code the Plan uses to identify specific individuals on a policy. Included for action types D and S. Defaults to '001' for D records if not provided.
20.	Relationship Code	2	178-179	Beneficiary's Relation to active employee: '01' = Beneficiary is Policy Holder '02' = Spouse '03' = Child '04' = Other Included for action types D and S. Field will contain value supplied on input.
21.	Partner Assigned DCN	15	180-194	The Document Control Number assigned by the VDSA partner. Included for action types D, S, and N. Field will contain value supplied on input.
22.	COBC DCN	15	195-209	COBC Document Control Number. Included for action types D, S, and N. Field will contain DCN created for this record by COB.
23.	Original Action Type	1	210	Type of Maintenance: 'D' = Drug Reporting record 'S' = Subsidy Reporting record 'N' = Non-Reporting record Included for action types D, S, and N. Field will contain value supplied on input.

VDSA Non-MSP Response File Layout - 500 bytes				
Field	**Name**	**Size**	**Displacement**	**Description**
24.	Action Type	1	211	Type of Maintenance applied by COB (COBC may change an S action to a D if RDS rejects the due to Part D enrollment): 'D' = Drug Reporting record 'S' = Subsidy Reporting record 'N' = Non-Reporting record Included for action types D, S and N. COB supplied value.
25.	Transaction Type	1	212	Type of Maintenance: '0' = Add Record '1' = Delete record '2' = Update record Included for action types D and S. Field will indicate type of maintenance applied.
26.	Coverage Type	1	213	Type of Coverage: 'U' = Drug Only (network Rx) 'V' = Drug with Major Medical (non-network Rx) 'W' = Comprehensive Coverage - Hosp/Med/Drug (network Rx) 'X' = Hospital and Drug (network Rx) 'Y' = Medical and Drug (network Rx) 'Z' = Health Reimbursement Account. (non-network Rx) '4' = Comprehensive Coverage - Hosp/Med/Drug (non-network Rx) '5' = Hospital and Drug (non-network Rx) '6' = Medical and Drug (non-network Rx) Included for action types D and S. Field will contain value supplied on input.
27.	Filler	1	214	Unused Field.

VDSA Non-MSP Response File Layout - 500 bytes				
Field	**Name**	**Size**	**Displacement**	**Description**
28.	Reason for Medicare Entitlement	1	215	Reason for Medicare Entitlement: 'A' = Aged 'B' = ESRD 'G' = Disabled Included for action types D and N. COB supplied value.
29.	S Disposition Code	2	216-217	Result from RDS processing. Included for records submitted with 'S' action types. RDS supplied value.
30.	S Disposition Date	8	218-225	Date of BENEMSTR/MBD or RDS Result for S disposition code. (CCYYMMDD). Included for records with an original S action types. RDS supplied value.
31.	Current Medicare Part A Effective Date	8	226-233	Effective Date of Medicare Coverage. (CCYYMMDD) Included for all action types. COB supplied value.
32.	Current Medicare Part A Termination Date	8	234-241	Termination Date of Medicare Coverage. (CCYYMMDD). * All zeros if open-ended or non-applicable. Included for all action types. COB supplied value.
33.	Current Medicare Part B Effective Date	8	242-249	Effective Date of Medicare Coverage. (CCYYMMDD). Included for all action types. COB supplied value.
34.	Current Medicare Part B Termination Date	8	250-257	Termination Date of Medicare Coverage. (CCYYMMDD). * All zeros if open-ended or non-applicable. Included for all action types. COB supplied value.

VDSA Non-MSP Response File Layout - 500 bytes				
Field	**Name**	**Size**	**Displacement**	**Description**
35.	Current Part D Effective Date	8	258-265	Effective Date of Medicare Part D Coverage. (CCYYMMDD). Included for all action types. COB supplied value.
36.	Current Part D Termination Date	8	266-273	Termination Date of Medicare Part D Coverage. (CCYYMMDD). * All zeros if open-ended or non-applicable. Included for all action types. COB supplied value.
37.	Medicare Beneficiary Date of Death	8	274-281	Medicare Beneficiary Date of Death (CCYYMMDD). Included for all action types. * All zeros if non-applicable. COB supplied value.
38.	MA/MA-PD Contractor Number	5	282-286	Medicare Advantage/Medicare Advantage with Prescription Drug Contractor number. Included for all action types. COB supplied value.
39.	MA/MA-PD Effective Date	8	287-294	Effective Date of Medicare Advantage/Medicare Advantage with Prescription Drug Coverage. (CCYYMMDD). Included for all action types. COB supplied value.
40.	MA/MA-PD Termination Date	8	295-302	Termination Date of Medicare Advantage/Medicare Advantage with Prescription Drug Coverage. (CCYYMMDD). * All zeros if open-ended or non-applicable. Included for all action types. COB supplied value.
41.	PDP Contractor Number	5	303-307	PDP Contractor number. Included for all action types when PDP contractor is different than MA contractor

VDSA Non-MSP Response File Layout - 500 bytes				
Field	**Name**	**Size**	**Displacement**	**Description**
42.	PDP Effective Date	8	308-315	Effective Date of MA-PD/PDP Coverage. (CCYYMMDD). Included for all action types when PDP contractor is different than MA contractor. COB supplied value.
43.	PDP Termination Date	8	316-323	Termination Date of MA-PD/PDP Coverage. (CCYYMMDD) * All zeros if open-ended or non-applicable. Included for all action types when PDP contractor is different than MA/PD contractor. COB supplied value.
44.	Error Code 1	4	324-327	Error Code 1 – Contains SP or RX error codes from COBC or RDS processing if applicable. COB supplied value for D/N records. RDS supplied value for S records.
45.	Error Code 2	4	328-331	Error Code 2 - Contains SP or RX error codes from COBC or RDS processing if applicable. COB supplied value for D/N records. RDS supplied value for S records.
46.	Error Code 3	4	332-335	Error Code 3 - May contain SP or RX error codes from COBC or RDS processing if applicable. COB supplied value for D/N records. RDS supplied value for S records.
47.	Error Code 4	4	336-339	Error Code 4 - May contain SP or RX error codes from COBC or RDS processing if applicable. COB supplied value for D/N records. RDS supplied value for S records.

VDSA Non-MSP Response File Layout - 500 bytes				
Field	**Name**	**Size**	**Displacement**	**Description**
48.	D/N Disposition Code	2	340-341	Result from processing of an action type D or N record. This will also be used to provide a disposition for D records converted from S records – in such case, the S disposition (Field 30) will also be populated. COB supplied value.
49.	D/N Disposition Date	8	342-349	Processing date associated with the D/N disposition code. (CCYYMMDD) COB supplied value.
50.	RDS Start Date	8	350-357	Start date for subsidy period. RDS supplied value.
51.	RDS End Date	8	358-365	End date for subsidy period. RDS supplied value.
52.	RDS Split Indicator	1	366	Indicates multiple subsidy periods within the plan year. Expect multiple records. Values: 'Y' if applicable. Space if not-applicable. RDS supplied value.
53.	ESRD Data	88	367-454	Future use. Space filled.
54.	Filler	46	455-500	Unused Field. Space filled.
Header Record				
1.	Header Indicator	2	1-2	Should be: 'H0'
2.	VDSA ID	4	3-6	'0001', '0002', etc. ID number assigned by COBC. (Previously labeled as "Plan Number.") Field will contain value supplied on input.
3.	Contractor Number	5	7-11	'11105' employer '11106' – insurer '11112' – BCBS Field will contain value supplied on input.
4.	File Type	4	12-15	'NMSR' – non-MSP input file

VDSA Non-MSP Response File Layout - 500 bytes				
Field	**Name**	**Size**	**Displacement**	**Description**
5.	File Date	8	16-23	CCYYMMDD COB supplied.
6.	RDS Application Number	10	24-33	Retiree Drug Subsidy ID number assigned by the RDS contractor that is associated with a particular RDS application. This application number will change each year when a new application is submitted. Required for files containing action type S. Field will contain spaces for action types D and N. Field will contain value supplied on input.
7.	Filler	467	34-500	Unused Field. Space filled.
Trailer Record				
1.	Trailer Indicator	2	1-2	Should be: 'T0'
2.	VDSA ID	4	3-6	'0001', '0002', etc. ID number assigned by COBC. (Previously labeled as "Plan Number.") Field will contain value supplied on input.
3.	Contractor Number	5	7-11	'11105' – employer '11106'- insurer '11112' – BCBS Field will contain value supplied on input.
4.	File Type	4	12-15	'NMSR' – non-MSP response file. Field will contain value supplied on input.
5.	File Date	8	16-23	CCYYMMDD COB supplied.
6.	Record Count	9	24-32	Number of records on file. COB Supplied.
7.	Filler	468	33-500	Unused Field. Space filled.

II. The Query Only HEW Input and Response File Layouts

F – *The Query Only HIPAA Eligibility Wrapper (HEW) Input File*. This is a Non-MSP File that is not accompanied by information about drug coverage – it only serves as a query file regarding Medicare entitlement of potential Medicare beneficiaries. If the partner does not use the Non-MSP Input file to report either prescription drug coverage secondary to Medicare, or retiree prescription drug coverage, the partner must use the HIPAA Eligibility Wrapper (HEW) software (provided by CMS) to submit a Query Only HEW Input File. Using this HEW software, the VDSA partner will translate ("wrap") the Non-MSP File into a HIPAA-compliant 270 eligibility query file format.

VDSA Query Only Input File Layout				
Field	***Name***	***Size***	***Displacement***	***Description***
1.	HIC Number	12	1-12	Medicare Health Insurance Claim Number (if available).
2.	Surname	6	13-18	Surname of Covered Individual.
3.	First Initial	1	19-19	First Initial of Covered Individual.
4.	DOB	8	20-27	Covered Individual's Date of Birth. (CCYYMMDD)
5.	Sex Code	1	28-28	Covered Individual's Sex: 0 = Unknown 1 = Male 2 = Female
6.	SSN	9	29-37	Social Security Number of the Covered Individual.
7.	Filler	1	38	Filler.

Header Record				
1.	Header Indicator	2	1-2	Should be: 'HO'
2.	VDSA ID	4	3-6	'0001', '0002', etc. ID number assigned by COBC (previously known as "Plan Number").
3.	Contractor Number	5	7-11	'11106' - Insurer

VDSA Query Only Input File Layout				
Field	***Name***	***Size***	***Displacement***	***Description***
				'11105' – Employer '11112' – BCBS
4.	File Type	4	12-15	'IACT' – Inactive.
5.	Cycle Date	8	16-23	File date 'CCYYMMDD'
6.	Filler	15	24-38	Unused Field.

Trailer Record				
1.	Trailer Indicator	2	1-2	Should be: 'TO'
2.	VDSA ID	4	3-6	'0001', '0002', etc. ID number assigned by COBC (previously known as "Plan Number").
3.	Contractor Number	5	7-11	'11106' – Insurer '11105' – Employer '11112' – BCBS
4.	File Type	4	12-15	'IACT' – Inactive.
5.	Cycle Date	8	16-23	File date 'CCYYMMDD'
6.	Record Count	9	24-32	Number of records on file.
7.	Filler	6	33-38	Unused Field.

G – *The Query Only HIPAA Eligibility Wrapper (HEW) Response File*. After CMS has processed the Query Only Input File it will return it to the VDSA partner as a Query Only Response File. The same CMS-supplied software that "wrapped" the Input File will now "unwrap" the Response file, so that it is converted from a HIPAA -compliant 271 eligibility response file format into the Query Only HEW Response File for the partner's use. **NOTE**: This response file does not have a header or trailer.

VDSA Query Only Response File Layout				
Field	***Name***	***Size***	***Displacement***	***Description***
1.	HIC Number	12	1-12	Medicare Health Insurance Claim Number.

VDSA Query Only Response File Layout				
Field	***Name***	***Size***	***Displacement***	***Description***
2.	Surname	6	13-18	Surname of Covered Individual.
3.	First Initial	1	19-19	First Initial of Covered Individual.
4.	DOB	8	20-27	Covered Individual's Date of Birth. (CCYYMMDD)
5.	Sex Code	1	28-28	Covered Individual's Sex: 0 = Unknown 1 = Male 2 = Female
6.	SSN	9	29-37	Social Security Number of the Covered Individual.
7.	Entitlement Reason (Medicare reason)	1	38	Reason for Medicare Entitlement: A = Working Age B = ESRD G = Disabled
8.	Current Medicare Part A Effective Date	8	39-46	Effective Date of Medicare Part A Coverage. (CCYYMMDD)
9.	Current Medicare Part A Termination Date	8	47-54	Termination Date of Medicare Part A Coverage. (CCYYMMDD) * Blank if ongoing.
10.	Current Medicare Part B Effective Date	8	55-62	Effective Date of Medicare Part B Coverage. (CCYYMMDD)
11.	Current Medicare Part B Termination Date	8	63-70	Termination Date of Medicare Part B Coverage. (CCYYMMDD) *Blank if ongoing.
12.	Medicare Beneficiary Date of Death	8	71-78	Beneficiary Date of Death. (CCYYMMDD)
13.	Medicare MA/MA-PD Contractor Number	5	79-83	Medicare Advantage/Medicare Advantage with Prescription Drug Contractor Number (Letter H plus 4 digits).
14.	Medicare MA/MA-PD Effective Date	8	84-91	Effective Date of Medicare Advantage/Medicare Advantage with Prescription Drug Coverage. (CCYYMMDD)

VDSA Query Only Response File Layout				
Field	***Name***	***Size***	***Displacement***	***Description***
15.	Medicare MA/MA-PD Termination Date	8	92-99	Termination Date of Medicare Advantage/Medicare Advantage with Prescription Drug Coverage. (CCYYMMDD) *Blank if ongoing.
16.	Disposition Code	2	100-101	01 = Record Accepted. Beneficiary is in File on CMS System. 51 = Beneficiary is not in File on CMS System.
17.	CMS Document Control Number	15	102-116	VDSA ID (102-105), Julian Date (106-110), Sequence Counter (111-116).

III. The VDSA Business Rules

The information following describes the data review process used by the COBC. These are the Business Rules for the four primary Input and Response files. They also apply, by extension, to the Query Only HEW Input files. The TIN reference file has no codified Business Rules at this time. No Business Rules are needed for the Implementation Questionnaire.

Conventions for Describing Data Values

The table below defines the data types used by COB for their external interfaces (inbound and outbound). The formatting standard defined for each data type corresponds to the data type identified for each field within the interface layout. This key is provided to assist in understanding the rules behind the formatting of the data values in the layout fields.

Data Type Key		
Data Type / Field	***Formatting Standard***	***Examples***
Numeric	• Zero through 9 (0 → 9) • Padded with leading zeroes	• Numeric (5): "12345" • Numeric (5): "00045"
Alpha	• A through Z • Left justified • Non-populated bytes padded with spaces	• Alpha (12): "TEST EXAMPLE" • Alpha (12): "EXAMPLE "

Alpha-Numeric	• A through Z (all alpha) + 0 through 9 (all numeric) • Left justified • Non-populated bytes padded with spaces	• Alphanum (8): "AB55823D" • Alphanum (8): "MM221 "

Text	• A through Z (all alpha) + 0 through 9 (all numeric) + special characters:
	  • Comma (,)
	  • Ampersand (&)
	  • Space ( )
	  • Dash (-)
	  • Period (.)
	  • Single quote (')
	  • Colon (:)
	  • Semicolon (;)
	  • Number (#)
	  • Forward slash (/)
	  • At sign (@)
	• Left justified
	• Non-populated bytes padded with spaces
		• Text (8): "AB55823D"
		• Text (8): "XX299Y "
		• Text (18): "ADDRESS@DOMAIN.COM"
		• Text (12): " 800-555-1234"
		• Text (12): "#34 "

Date	• Format is field specific • Fill with all zeroes if empty (no spaces are permitted)	• CCYYMMDD (e.g. "19991022") • Open ended date: "00000000"
Filler	• Populate with spaces	
Internal Use	• Populate with spaces	
The above standards apply unless otherwise noted in layouts.		

VDSA Processing: System Requirements

Existing VDSA (Voluntary Data Sharing Agreement) Requirements that apply to the new MSP and Non-MSP files have been modified to assure that data from all VDSA partners (both employers and insurers) is processed consistently.

- The System shall be able to receive an external file from a VDSA partner. The System shall be able to confirm the external VDSA partner file format.
- The System shall be able to match the valid VDSA partner external file to the Eligibility Database.
- The System shall be able to update a CMS MSP record based on differences found between a valid VDSA partner external file and the Eligibility Database.
- The System shall be able to create an MSP transaction file from the VDSA partner MSP record and the Beneficiary Master Record.
- The System shall be able to receive an external file from a Voluntary Insurer.
- The System shall display error descriptions in CHAPS for severe errors identified on BCBS and VDSA files.

New MSP Processing Requirements:

- The System shall accept an MSP record from a VDSA for reporting of MSP and/or drug coverage.

- The System shall edit drug records received on the VDSA MSP file for the presence of mandatory fields.

- The System shall match drug records received on the VDSA MSP file against the COB drug coverage database.

- The System shall apply RX error codes generated by COB to invalid MSP drug records to return them on the MSP response file.

- The System shall forward validated VDSA MSP drug records to MBD (Medicare Beneficiary Database).

- The System shall establish a drug coverage record in the COB system for drug records sent to MBD.

- The System shall accept a response file from MBD for submitted drug records.

- The System shall update the MBD disposition for the drug record on the drug coverage table.

- The System shall notify VDSA submitters on the MSP Response File of the disposition of MSP and drug records provided.

- The System shall accept lower case characters on a MSP Input File in text fields.

- The System shall reject MSP records submitted by VDSA partners when the employer size does not meet the minimum requirements to be responsible for MSP coverage. This includes situations where the employer has less than 100 employees and the beneficiary's entitlement reason is G (Disabled).

New Non-MSP Processing Requirements:

1. The System shall accept a non-MSP record from a VDSA for reporting of employer subsidy.

2. The System shall forward employer subsidy records submitted on a VDSA non-MSP file to the RDS Contractor.

3. The System shall convert employer subsidy records rejected by the RDS Contractor for beneficiaries that are already enrolled in Part D to drug records

when the record pertains to a Part D beneficiary and contains all the required data.

4. The System shall notify VDSA submitters on the Non-MSP Response File when a subsidy record is converted by COB to a drug record.

5. The System shall notify VDSA submitters on the Non-MSP Response File when a subsidy record was rejected by RDS as not eligible for the subsidy.

6. The System shall accept a non-MSP record from a VDSA for reporting of other drug coverage.

7. The System shall edit drug records received on the VDSA non-MSP file for the presence of mandatory fields.

8. The System shall match drug records received on the VDSA non-MSP file against the drug coverage database.

9. The System shall apply RX error codes generated by COB to invalid non-MSP drug records to return them on the Non-MSP Response file.

10. The System shall forward validated VDSA non-MSP drug records to MBD.

11. The System shall establish a drug coverage record in the COB system for supplemental drug records sent to MBD.

12. The System shall accept a response file from MBD for submitted supplemental drug records.

13. The System shall update the MBD disposition for the supplemental drug record on the Drug Coverage Table.

14. The System shall notify VDSA submitters on the Non-MSP Response File of the disposition of supplemental drug records provided.

15. The System shall accept lower case characters on a Non-MSP Input File in text fields.

16. The System shall forward unsolicited subsidy record updates from RDS to VDSA partners.

Methodological Description

Introduction

The scope of the VDSA process - determining primary versus secondary payer responsibility - will be expanded to include the reporting of prescription drug coverage information to CMS. Under the existing Part A/B MSP rules based on employer size, prescription drug coverage that is part of an active employee's Medicare GHP coverage will remain primary to Medicare.

In addition to the drug information that is part of standard MSP situations, VDSA partners are now able to report non-MSP drug coverage to Medicare, and coverage data to support employer Retiree Drug Subsidy operations.

In order to provide a means for participants in VDSAs to report prescription drug coverage to the COBC, new input and response file formats have been developed that include fields for prescription drug plan information about active and inactive beneficiaries.

The new **active file** will be known as the **MSP File**. The new **inactive file** format will be known as the **Non-MSP File**. VDSA participants will be able to report prescription drug information and employer subsidies on the non-MSP files, and inquire on beneficiary entitlement status. Legacy VDSA partners have been encouraged to switch over to the new MSP and non-MSP formats so that all prescription drug data can be reported. All VDSA partners using pre-MMA VDSA documents (Legacy Partners) are expected to have migrated to all of the new VDSA record layouts by the end of March, 2006.

Only partners submitting D or S records may use the Non-MSP File for "N" queries. Those not submitting D or S records (that is, those wishing to submit nothing but a Non-MSP "N" record) must continue to use the Query Only HEW Input File and accompanying HEW software.

All VDSA partners will need to submit a TIN Reference File to go with the new MSP files. The TIN Reference File may now include a new "pseudo" TIN indicator. BCBS plans will also need to submit a TIN Reference File to use the new BCBS VDSA format. If the VDSA partner is unable to obtain the TINs associated with their file, the TIN field on the input file may be populated with an identifying number that matches a pseudo TIN on their TIN Reference File. The pseudo TIN indicator will be added to each TIN record that is populated with a 'Y,' indicating that a pseudo TIN is being used. The TIN Reference File should contain a record for each TIN included in the file, including the TIN associated with the entity submitting the file; at least one of the TIN records should contain a valid TIN. If a pseudo TIN is used, the TIN will not be used for anything except to populate the address in the MSP (CWF Maintenance Transaction) record. *If an employer reports a pseudo TIN for itself, the employer will not be systematically excluded from its reporting requirements under the IRS/SSA/CMS Data Match.*

Error Codes

Following is an introduction to the subject of Error Code Reporting in both the MSP and Non-MSP Response Files. A comprehensive listing of all error codes that a partner may encounter can be found in Section IV, The Complete Disposition and Edit Code List.

Most error reporting can be avoided by completing required fields on the Input File. Required fields include the Surname of Covered Individual, First Initial, Date of Birth, Sex, a DCN assigned by the VDSA partner, Transaction Type, Coverage Type, individual's SSN, Effective Date, Termination Date, Patient Relationship, Subscribers' First and Last name, Subscriber's SSN, Employer Size, Group Health Plan Number, Policy Number, Employee Coverage Election, Employee Status, Employer TIN, and Insurer TIN.

As before, MSP processing will continue to generate SP errors (MSP Maintenance Transaction errors) and disposition codes for records with duel MSP/Drug coverage. All of the existing CWF SP errors still apply. For Coverage Type A, J, and K, the required input fields will not change. The combination Coverage Types that include Part A/B coverage also need to include the fields required by CWF. These combination Coverage Types include V, W, X, Y, 4, 5, and 6.

For Drug only, Subsidy, or Non-MSP drug record processing, the COBC will need to apply similar error checks and supply the results to the VDSA partner in the response file. The SP errors that will specifically apply for drug records are as follows:

Error Code	Description
SP 12	Invalid HIC Number or SSN. At least one of the fields must contain alpha or numeric characters. Both fields cannot be blank or contain spaces.
SP 13	Invalid Beneficiary Surname. Field must contain alpha characters. Field cannot be blank, contain spaces or numeric characters.
SP 14	Invalid Beneficiary First Name Initial. Field must contain alpha characters. Field cannot be blank, contain spaces, numeric characters or punctuation marks.
SP 15	Invalid Beneficiary Date of Birth. Field must contain numeric characters. Field cannot be blank, contain spaces or alpha characters. Day of the month must be correct. For example, if month = 02 and date = 30, the record will reject.
SP 16	Invalid Beneficiary Sex Code. Field must contain numeric characters. Field cannot be blank, contain spaces or alpha characters. Acceptable numeric characters include the following: 1 = Male 2 = Female

Error Code	Description
SP 19	Invalid Transaction Type. Field must contain numeric characters. Field cannot be blank, contain alpha characters or spaces. Acceptable numeric characters include the following: 0 = Add Record 1 = Delete Record 2 = Update Record
SP 24	Invalid Coverage Type. Field must contain alpha characters. Field cannot be blank or contain numeric characters. Valid values are: A, J, K, U, V, W, X, Y, Z, 4, 5, 6 for MSP layout U, V, W, X, Y and Z for Non-MSP layout
SP 31	Invalid Effective Date. Field must contain numeric characters. Field cannot be blank, contain spaces, alpha characters or all zeros. Number of days must correspond with the particular month.
SP 32	Invalid MSP Termination Date. Field must contain numeric characters. Date must correspond with the particular month – CCYYMMDD. For example, 02/27/1997 is acceptable, but not 02/30/1997. Cannot be earlier than the MSP effective date. If there is no termination date (coverage is still active), must use zeros (not spaces) in this field.
SP 34	Invalid Subscriber First Name. Field may contain alpha characters. If field is not used, field must contain spaces. Field cannot be blank or contain numeric characters. Only alpha characters used when subscriber is identified.
SP 35	Invalid Subscriber Last Name. Field may contain alpha characters. If field is not used, field must contain spaces. Field cannot be blank or contain numeric characters. May use spaces instead of apostrophe. Only alpha characters may be used when subscriber is identified.
SP 49	No valid record exists for delete request. Attempt to delete a nonexistent MSP will cause a reject.
SP 52	Invalid patient relationship code
SP 62	Incoming termination date is less than effective date. MSP termination date must be greater than the effective date.

Additionally, COBC will provide RX-specific errors:

Error Code	Description
RX 01	Missing RX ID
RX 02	Missing RX BIN
RX 03	Missing RX Group Number
RX 04	Missing Group Policy Number
RX 05	Missing Individual Policy Number

Error Code	Description
RX 06	Missing/Invalid Retiree Drug Subsidy Application Number
RX 07	Coverage period does not fall within current Medicare Part D Coverage period

MSP Processing

MSP records should be submitted for active beneficiaries with hospital and/or medical coverage, and/or prescription drug coverage.

New fields included to the MSP format for drug coverage reporting include an RxID, Rx Group, RxBin, PCN, Person Code and Toll-free Phone Number.

The Coverage Type field will have several additional values besides the existing values (i.e. J, K, and A) that are passed to CWF and MBD since the coverage can now include drug. These new values are:

U – Drug coverage only
V – Drug coverage with Major Medical
W – Comprehensive coverage (includes Hospital, Medical and Drug)
X – Hospital and drug coverage
Y – Medical and drug coverage
Z – Health reimbursement account (non-network Rx)
4 – Comprehensive coverage -Hosp/Med/Drug (non-network Rx)
5 – Hospital and Drug (non-network Rx)
6 – Medical and Drug (non-network Rx)

Records containing MSP information will be processed in the same way as were those in the previous active process. An MSP record will be created and sent to CWF. The existing edits will continue to be applied and a file will still be created containing the responses received, with any applicable SP errors included.

Records containing a coverage type indicating drug coverage will go through a similar edit process. Separate drug coverage records will be created from the input record.

The drug record will be compared to the COBC's existing drug coverage table for matches for HICN, effective date, patient relationship, VDSA ID/Contractor number, and coverage type. If these fields all match, the record will be considered an update. Updates to records that are not found will be rejected. Otherwise the record will be added to the table and forwarded to MBD.

When a record is received indicating that the coverage type is for combination coverage that includes both MSP and drug, the MSP information will be split off to create a transaction that will be sent to CWF. The drug information will be split into separate

transactions that will be sent to MBD. The coverage type on the MSP record will be converted to the CWF corresponding value. An ‘X’ will be translated to a ‘J’, a ‘Y’ translates to ‘K’, a ‘W’ to ‘A’, a ‘4’ to ‘A’, a ‘5’ to ‘J’, and a ‘6’ to ‘K’.

The entitlement reason code that was included on the active record layout will not be included on the new MSP layout. The entitlement reason will be provided on the response file, but will no longer be required on the input since it can change, and submitters won’t always know the correct value.

Non-MSP Processing

VDSA partners will be able to use the new non-MSP record layout for three reasons. They are identified on the input record by action type:

1. Subsidy Reporting (S) – To utilize the VDSA process to satisfy the reporting requirement of employer subsidy to the Retiree Drug Subsidy (RDS) Contractor.

2. Drug Coverage Reporting (D) – To allow reporting of other drug coverage to MBD for TrOOP to utilize.

3. Non-Reporting (N) – To determine entitlement to Medicare.

An Action Type of D, S, or N will always be required to determine the purpose of the submission.

For Non-Reporting records the following fields are required in addition to action type:

- HICN or SSN
- Surname
- First initial
- Date of birth
- Sex

(DCN and middle initial can be populated if available.)

When a non-MSP ‘D’ record is received with a coverage type that indicates there is prescription drug coverage (U, V, W, X, Y, Z, 4, 5, 6), COBC will attempt to create an RX transaction. The record will go through the beneficiary matching process first to establish that beneficiary data is valid. Records that aren’t matched with an active beneficiary will be rejected by the COB system.

The drug record will be compared to the COBC’s existing drug coverage table for matches for HICN, effective date, patient relationship, coverage type, and VDSA ID. If these fields all match the record will the considered an update. Otherwise the record will be added to the data table and forwarded to MDB.

When a record is received with an Action Type of 'S,' for subsidy reporting, it will not be edited to verify that all the fields were provided for the type of coverage indicated. The information will be sent to RDS to validate the employer subsidy eligibility of the prescription drug coverage for the beneficiary. COBC will forward all RDS responses to the submitting data sharing agreement (DSA) partner.

If the record comes back from RDS with a disposition code indicating that the beneficiary is ineligible for the subsidy because he or she is already enrolled in part D, the COBC will change the action type to 'D' on the response record. The 'S' Disposition Code will get populated with the rejected reason. The RDS application number will be passed back to the VDSA partner on the response. The drug record will be validated for completeness of mandatory fields. After it is verified as complete, the record will be forwarded to MDB and a drug record created in the drug coverage database.

But if the subsidy record does not contain enough information to create the drug record it will be rejected, with the applicable SP errors included in the response. If the dates applied for the subsidy are different than those submitted, the revised dates will be provided in separate fields on the response.

Possible 'S' Record Disposition Codes are:

Edit	Description
01	Subsidy record accepted
02	Application pending or in process at RDS (COBC internal use)
03	Rejected - Beneficiary record not found.
04	Rejected - Beneficiary already enrolled in Part D
05	Rejected – Beneficiary not Medicare entitled
06	Rejected - Subsidy record rejected for errors
07	Rejected - Associated RDS application was rejected
08	Rejected - Beneficiary deceased
09	Rejected – Missing header/trailer record (for RDS interface only)

Because periods of eligibility can be interrupted, or a retiree is not eligible for the subsidy for the entire year, it is possible to receive multiple response records for one 'S' record submitted. The RDS Split indicator will be populated with a 'Y' in each such record. The records will all contain the original DCN. For example one record may include dates for 01/01/2006 through 03/31/2006 with a'05' reason if the person is not yet eligible for Medicare. The second record may have dates 04/01/2006 through 12/31/2005 covering the remainder of the plan year with a '01' subsidy record accepted status.

Business Rules

MSP Processing

1. MSP records that contain both MSP and drug data will receive one response record. The disposition of the MSP and drug record will be provided in separate fields.

2. If the MSP response from CWF is not available, COBC will hold off on sending the drug response until both parts of the record can be reported on.

3. MSP records for CWF will continue to go through the existing edit process.

4. COBC will attempt to create a drug coverage record for coverage types U, V, W, X, Y, Z, 4, 5, and 6.

5. Since the only rejects MBD plans on sending COBC will be for ineligible beneficiaries, all drug coverage validation will be based on COB applied edits.

6. Drug records will be considered accepted when they have passed the COB edits and have been forwarded to MBD.

7. Action type is required for all MSP records.

8. Required fields for drug records are HICN or SSN, surname, first initial, date of birth, sex, effective date, relationship code, and coverage type plus group health plan number and policy number for coverage type ‘V’. Rx ID and RxBIN are required for coverage type ‘U’,’W’, ‘X’, ‘Y’, and ‘Z’. DCN, middle initial, termination date, Rx PCN, Rx Group Number, and person code should be provided if available.

9. COBC will not send incomplete drug records to MBD.

10. The matching criteria for drug coverage will be HICN, effective date, patient relationship, plan number, and coverage type.

11. Although lower case characters will be accepted in the MSP file, the text in the response file will be returned in upper case since COBC will need to convert the text to upper case in order to process the file.

12. MSP records will be rejected if the employer does not meet the size requirement for MSP. If the EMP-SIZE = '1' (20 - 99 employees) and the entitlement reason = 'G,' the record will be returned with an 'SPES' (SP – Employer Size).

13. Drug records passed to the Drug Engine from the VDSA MSP files will include an indicator that the coverage is primary coverage.

14. For a drug record sent in on an MSP file to be sent to MBD the coverage period must fall within the current Part D coverage period.

15. The effective date on a Part D coverage received on the MSP file will be defaulted to the start date of the current Part D coverage period.

16. The termination date for a Part D coverage received on the MSP file will be defaulted to the end date of the current Part D coverage period.

Non-MSP Processing

1. Action type will be required on all non-MSP records.

2. Required fields for non-Reporting records are HICN or SSN, surname, first initial, date of birth, and sex. DCN and middle initial can be populated if available.

3. COB will edit Subsidy records for header/trailer information, record length and action type. Only records with the 'S' indicator will be forwarded to RDS. RDS will pass their disposition and/or error codes back to COBC who will reformat the response into the non-MSP format and return to the VDSA partner. Additional editing of 'S' records will only occur if the subsidy is rejected because the beneficiary is already enrolled in Part D. Then COB will confirm that the required fields are present to convert the record to a 'D' drug record. These fields are HICN or SSN, surname, first initial, date of birth, sex, effective date, relationship code, transaction type, coverage type, group health plan number and policy number for coverage type 'V, 4, 5, or 6'. Rx ID and RxBIN are required for coverage type 'U', 'X', and 'Y'. Type 'Z' records need to include either the group health plan number and policy number, or the Rx ID and Rx BIN fields. DCN, middle initial, termination date, Rx PCN, Rx Group ID and person code should be provided if available. Subsidy records rejected because the beneficiary was not entitled or because insufficient information was submitted to RDS will be returned in the non-MSP response format with the error codes supplied by RDS.

4. Accepted subsidy records will also be returned without editing by COBC.

5. Required fields for other drug records are HICN or SSN, surname, first initial, date of birth, sex, effective date, relationship code, transaction type, and coverage type plus Policy number for coverage type 'V, Z, 4, 5, or 6'. Rx ID and RxBIN are required for coverage type 'U, W X, or Y.' DCN, middle initial, termination date, Rx PCN, Rx Group ID and person code should be provided if available.

6. COBC will not edit employer subsidy records prior to sending them to RDS.

7. Only other drug records for current beneficiaries will be sent to MBD.

8. COBC will not create records in the COBC databases for accepted subsidy records.

9. COBC will not send incomplete other drug records to MBD.

10. Although lower case characters will be accepted in the non-MSP file, the text in the response file will be returned in upper case since COBC will need to convert the text to upper case in order to process the file.

11. In instances where an S record is converted to a D record, the 'S' disposition code in the record will be used for the disposition of the S record. The 'D/N' disposition field would be for the disposition of the converted D record. If the record was submitted as a D or N action type only the D/N disposition fields will be used.

12. COBC will zero fill termination date fields instead of leaving the field blank for open -ended coverage or where the date is not applicable.

13. Drug records passed to the Drug Engine from the VDSA non-MSP files will include an indicator that the coverage is supplemental coverage.

14. COBC will add all the entitlement information that is available (Part A, B and D) into all the response records regardless of whether the submitted record was a D, S or N.

15. COB will pass the split indicator to the VDSA partner on the response.

16. In cases were a split indicator is used, COBC will include the entitlement information in both records. Each record will contain its individual status and errors if applicable.

17. Drug coverages sent on the non-MSP file will be sent to MBD using the plan dates submitted.

18. Drug coverages sent on the non-MSP file will be sent to MBD for matched beneficiaries that have a Part D enrollment date.

IV. The Complete Disposition and SP Edit Code List

For your ready reference, we are including the codes that constitute the complete set of Disposition and SP Edits. These are all the edit and disposition codes that the Centers for Medicare & Medicaid Services (CMS) may use in an Update File Response forwarded to an Agreeing Partner. Subsets are shown elsewhere in the business rules, above.

Keep in mind that not all these codes will apply to all response files you can receive from the COB Contractor (COBC). Please contact the COBC if you have questions about any of the Disposition or SP Edit codes.

NOTES: Codes marked with an asterisk (*) are "front end" consistency edits. These codes show conditions on the face of the record that are unrecognizable or unallowable for that field (*e.g.*, the field requires numeric characters but the submitted record contains alpha characters).

Codes that do not have an asterisk (*) show discrepancies that result from information on the submitted record conflicting with or not matching the information on CMS's Systems.

DISPOSITION AND SP EDIT CODE LIST

DISPOSITION CODES	DESCRIPTION
01	Record accepted by Common Working File (CWF) as an "Add" or a "Change" record.
SP	Transaction edit; record returned with at least one SP or RX edit (specific SP and RX edits are described below).
50	Record still being processed by CMS. Internal CMS use only*; no Agreeing Partner action is required.*
51	Beneficiary is not in file on CMS System. Record will not be recycled. Beneficiary most likely not entitled to Medicare. *Agreeing Partner should re-verify beneficiary status based on information in its files.*
52	Record still being processed by CMS. Internal CMS use only; *no Agreeing Partner action is required.*
53	Record in alpha match at CMS. Internal CMS use only; *no Agreeing Partner action is required.*
55	Name/Personal Characteristic Mismatch. Name or personal characteristic of beneficiary does not match the Health Insurance Claim Number (HICN) on Medicare's files. *Agreeing Partner* needs to re-verify name, HICN, date of birth and sex based on information in its files; then resubmit on next exchange file.
61	Cross-Reference Data Base Problem. Internal CMS use only; *no Agreeing Partner action is required.*
AB	CWF problem that can only be resolved by CWF Technician. Internal CMS use only; *no Agreeing Partner action is required.*
CI	Processing Error. Internal CMS use only; *no Agreeing Partner action is required.*

Following are the edit codes applied by the Common Working File (CWF) to Medicare Secondary Payer (MSP) records; an Agreeing Partner may receive these in their response file.

SP EDIT CODES	DESCRIPTION	No Partner Action Required	Agreeing Partner Action Required
SP 11	Invalid MSP Transaction Record Type. Mandatory field ("Mandatory") internal CMS use only; non-blank, must be valid record type. *No Agreeing Partner action is required.*	X	
*SP 12	Invalid HICN (Mandatory). Field must contain alpha and numeric characters. You received this error because: 1) either an invalid character was provided in this field, 2) we were unable to match the Social Security number (SSN) you supplied with a valid HICN, or 3) you provided an invalid HICN, and we could not find a match with the SSN. When you do not know the HICN, submit spaces in this field.		X
*SP 13	Invalid Beneficiary Surname (Mandatory). Field must contain alpha characters. Field cannot be blank or contain spaces or numeric characters.		X
*SP 14	Invalid Beneficiary First Name Initial (Mandatory). Field must contain alpha characters. Field cannot be blank or contain spaces, numeric characters, or punctuation marks.		X
*SP 15	Invalid Beneficiary Date of Birth (Mandatory). Field must contain numeric characters. Field cannot be blank or contain spaces or alpha characters. Day of the month must be correct. For example, if month = 02 and date = 30, the record will reject.		X
*SP 16	Invalid Beneficiary Sex Code (Mandatory). Field must contain numeric characters. Field cannot be blank, contain spaces or alpha characters. Acceptable numeric characters include the following: 0 = Unknown 1 = Male 2 = Female		X
*SP 17	Invalid Contractor Number (Mandatory). Non-blank, numeric. Must be valid, CMS-assigned Contractor Number. Internal CMS use only.	X	
*SP 18	Invalid Document Control Number (DCN). CMS replaces the Agreeing Partner's original DCN with CMS' DCN. CMS automatically provides a DCN, so the Partner should not receive this error. Mandatory for MSP Transactions only. Blank for all others. (Valid Values: Alphabetic, Numeric, Space, Comma, & - ' . @ # /; :)	X	
*SP 19	Invalid Maintenance Transaction Type (Mandatory). This error results from what is provided in the type of record transaction		X

SP EDIT CODES	DESCRIPTION	No Partner Action Required	Agreeing Partner Action Required
	field. Field must contain numeric characters. Field cannot be blank, contain alpha characters or spaces. Acceptable numeric characters include the following: 0 = Add Record 1 = Delete Record 2 = Update Record		
*SP 20	Invalid Validity Indicator (Mandatory). CMS will generate a 'Y' in this field on the response file. (Y = Beneficiary has MSP coverage.) However, other errors on this listing may be related to the validity indicator provided by CMS. Field cannot be blank or contain a space.	X	
*SP 21	Invalid MSP Code (Mandatory). COB will apply an MSP code based on the entitlement reason for the beneficiary. Field cannot be blank or contain alpha characters. Acceptable numeric characters include the following: A = Working Aged G = Disabled B = ESRD	X	
SP 22	Invalid Diagnosis Code (1-5 spaces allowed). Field is not used; field must be blank. If data is entered, CMS will fill this field with blanks. Valid Values: Alphabetic, Numeric, Space.	X	
SP 23	Invalid Remarks Code (1-3 spaces allowed). Field is not used; field must be blank. If data is entered, CMS will fill this field with blanks.	X	
*SP 24	Invalid Insurer Type. Field must contain alpha characters. Field cannot be blank or contain numeric characters. Type - 'A-M', and spaces are valid. Acceptable alpha characters include the following: J = Hospital only coverage plan – A plan which covers only inpatient hospital services. K = Medical coverage only plan – A plan which covers only non-inpatient medical services. A = Hospital and Medical coverage plan. **Note: COB derives this value from the coverage type submitted. Types of coverage that include drug coverage - W, X, Y, 4, 5, 6 - are converted to CWF values as follows:* *W is translated to A for CWF and U for MBD.* *X is translated to J for CWF and U for MBD.*		X

SP EDIT CODES	DESCRIPTION	No Partner Action Required	Agreeing Partner Action Required
	Y is translated to K for CWF and U for MBD *Z is translated to V for MBD.* *4 is translated to A for CWF and V for MBD.* *5 is translated to J for CWF and V for MBD.* *6 is translated to K for CWF and V for MBD.*		
*SP 25	Invalid Insurer Name. Place the name of the insurer in this field. Spaces are allowed between words in an insurer plan name. Field may contain alpha and/or numeric characters, commas, & - ' . @ # / : ;. Field cannot be blank or contain numeric characters. If the MSP Insurers name is equal to SUPPLEMENT, SUPPLEMENTAL, INSURER, MISCELLANEOUS, CMS, ATTORNEY, UNKNOWN, NONE, N/A, UN, MISC, NA, NO, BC, BX, BS, BCBX, BLUE CROSS, BLUE SHIELD, or MEDICARE, SP 25 error will occur.		X
*SP 26	Invalid Insurer Address 1 and/or Address 2. Place the insurer address in this field. Spaces are allowed between words in a plan address. Field may contain alpha and/or numeric characters, commas, & - ' . @ # / : ; Field cannot be blank.		X
*SP 27	Invalid Insurer City. Field cannot contain numeric characters. Spaces are allowed for multi-city word name. If field is not used, field must contain spaces. Field may contain alpha characters, commas, & - ' . @ # / : ;		X
*SP 28	Invalid Insurer State. Field may contain alpha characters. If field is not used, field must contain spaces. Alpha characters provided must match U.S. Postal State Abbreviation Table. When the MSP Insurers state does not match a state code on the U.S. Postal Service state abbreviation table, SP28 error will occur.		X
*SP 29	Invalid Insurer Zip Code. First five positions must be numeric; last four positions may be numeric or spaces.		X
*SP 30	Invalid Policy Number. If field is not used, field must contain spaces. Field may contain alpha and/or numeric characters, commas, & - ' . @ # / : ;		X
*SP 31	Invalid MSP Effective Date (Mandatory). Field must contain numeric characters. Field cannot be blank, contain spaces, alpha characters or all zeros. The date must be in the following format-CCYYMMDD. Number of days must correspond with the particular month. For example, the date 19500230 is not acceptable (February cannot have 30 days). MSP effective date must be less than or equal to the current date and cannot be a future date. For example, today is 20030312 and an Agreeing Partner submits a record with an MSP effective date of 30000901.		X

SP EDIT CODES	DESCRIPTION	No Partner Action Required	Agreeing Partner Action Required
	Since this is a future date, the agreeing partner will receive an SP 31.		
*SP 32	Invalid MSP Termination Date (Mandatory). Field must contain numeric characters. The date must be in the following format-CCYYMMDD. Number of days must correspond with the particular month. For example, the date 19500230 is not acceptable (February cannot have 30 days). Plan termination date cannot be earlier than the MSP effective date. If there is no termination date (coverage is still active), you must use zeros (not spaces) in this field. For Working-Aged beneficiaries, the termination date cannot be greater than the current date plus 6 months. For Disability beneficiaries, the termination date cannot be greater than the first day the beneficiary turned 65. Will accept future date for ESRD up to 30 months. Termination date must be greater than 30 days after the MSP effective date. If Contractor Number is that of the Internal Revenue Service/Social Security Administration/Centers for Medicare & Medicaid Services (IRS/SSA/CMS) Data Match project ('11102' or '77777'), the Term Date may be equal to, or greater than, the Effective Date.		X
*SP 33	Invalid Patient Relationship (Mandatory). Field must contain numeric characters. First character must be zero and the second character can only be 1, 2, 3, or 4. Other characters used besides 01 - 04 are invalid and will result in an SP 33. Field cannot be blank or contain alpha characters. Acceptable numeric values are as follows: 01 = Beneficiary 02 = Spouse 03 = Child* 04 = Other * Applies only for children covered under the ESRD provision or disabled adult children covered under the disability provision.		X
*SP 34	Invalid Subscriber First Name. Field may contain alpha and/or numeric characters, spaces, commas, & - ' . @ # / : ; If field is not used, field must contain spaces.		X
*SP 35	Invalid Subscriber Last Name. Field may contain alpha and/or numeric characters, spaces, commas, & - ' . @ # / : ; If field is not used, field must contain spaces.		X
*SP 36	Invalid Employee ID Number. Field may contain alpha and/or numeric characters, spaces, commas, & - ' . @ # / : ; If field is		X

SP EDIT CODES	DESCRIPTION	No Partner Action Required	Agreeing Partner Action Required
	not used, field must contain spaces.		
SP 37	Invalid Source Code. Field is not used; field must be blank. Internal CMS use only.	X	
SP 38	Invalid Employee Information Data Code. Internal CMS use only. Valid alphabetic values are 'F', 'M', 'P', and 'S'. If field is not used, field must contain spaces.	X	
*SP 39	Invalid Employer Name. Field must contain alpha and/or numeric characters, commas, & - ' . @ # / : ;. If field is not used, field must contain spaces. (For those beneficiaries that are Working Aged or Disabled, this field should always contain the name of the actual employer.)		X
*SP 40	Invalid Employer Address. Field must contain alpha and/or numeric characters, commas, & - ' . @ # / : ;. If field is not used, field must contain spaces. (For those beneficiaries that are working aged or disabled, this field should always contain the address of the actual employer.)		X
*SP 41	Invalid Employer City. Field may contain alpha and/or numeric characters. If field is not used, field must contain spaces. Valid characters include commas, & - ' . @ # / : ;		X
*SP 42	Invalid Employer State. Field must contain alpha characters. If field is not used, field must contain spaces. Field cannot be blank. Alpha characters provided must match U.S. Postal State Abbreviation Table.		X
*SP 43	Invalid Employer Zip Code. First five positions may be numeric; the last four positions may be spaces. If field is not used, field must contain spaces. Field cannot contain alpha characters. Must be within valid zip code range on zip code table. If a foreign country, use 'FC' for state code. The first five digits can be zeros, and last four can be blanks.		X
*SP 44	Invalid Insurance Group Number. If field is not used, field must contain spaces. Field may contain alpha and/or numeric characters, commas, & - ' . @ # / : ;		X
*SP 45	Invalid Insurance Group Name. If field is not used, field must contain spaces. Field may contain alpha and/or numeric characters, commas, & - ' . @ # / : ;		X
SP 46	Invalid Pre-Paid Health Plan Date. Numeric, number of days must correspond with the particular month. Internal CMS use only.	X	

SP EDIT CODES	DESCRIPTION	No Partner Action Required	Agreeing Partner Action Required
SP 47	Beneficiary MSP Indicator not on for delete transaction. An attempt was made to delete an MSP record where there is no MSP indicator on the beneficiary Medicare record. According to CMS records Medicare has always been the primary payer.		X
SP 48	MSP auxiliary record not found for delete data transaction. This edit occurs when an attempt is made to delete a non-existent MSP record.		X
SP 49	MSP auxiliary occurrence not found for delete data transaction. Where there is an existing MSP period, the incoming record must match on certain criteria so the system can differentiate among various periods of MSP on the beneficiary's Medicare file. These criteria are: patient relationship, MSP effective date, MSP type, and insurer type. An SP 49 is received when a Partner attempts to delete an occurrence that is not on CWF, or one for which there is no "match" on CWF, or you send in a delete transaction for a record that has been previously deleted by the Partner or another entity and the record no longer exists.		X
SP 50	Invalid function for update or delete. Contractor number unauthorized. Internal CMS use only.	X	
SP 51	MSP auxiliary record has 17 occurrences and none can be replaced. Internal CMS use only.	X	
*SP 52	Invalid patient relationship code (“PRC”). (Mandatory) The MSP Code must correspond with valid PRC as cited below. MSP Code — Patient Relationship Code A = Working Aged — 01 = Beneficiary; 02 = Spouse G = Disabled — 01 = Beneficiary; 02 = Spouse; 03 = Child; 04 = Other B = ESRD — 01 = Beneficiary; 02 = Spouse; 03 = Child; 04 = Other For example, you will receive this edit when the MSP Code is equal or determined to be "A" "G" or "B" by the COBC and one of the following occurs: 1) If the MSP Code is equal to "A" and the MSP patient relationship does not equal "01" or "02," or 2) the MSP code is equal to "G" "2" or "3" and the patient relationship		X

SP EDIT CODES	DESCRIPTION	No Partner Action Required	Agreeing Partner Action Required
	does not equal '01' '02' '03' , or "04."		
SP 53	MSP Code G or B overlaps another Code A, G, or B. Internal CMS use only.	X	
SP 54	MSP Code A or G has an effective date that is in conflict with the calculated date the beneficiary reaches 65 years old. For MSP Code A, the effective date must not be less than the date at age 65. For MSP Code G, the effective date must not be greater than the date at age 65.		X
SP 55	MSP effective date is less than the earliest beneficiary Part A or Part B entitlement date. MSP can only occur once the beneficiary becomes entitled to Medicare Part A or Medicare Part B. The MSP effective date cannot be less than the Medicare Part A or Part B effective date. An MSP Effective Date that is an invalid date will also cause SP 55 error.		X
SP 56	MSP pre-paid health plan date must equal or be greater than the MSP effective date or less than MSP termination date. Internal CMS use only.	X	
SP 57	Termination date greater than 6 months before date of accretion. Internal CMS use only.	X	
*SP 58	Invalid insurer type, MSP code, and validity indicator combination. Insurer type must equal J, K, or A.		X
*SP 59	Invalid insurer type and validity indicator combination. Partners should not receive this edit. Internal CMS use only.	X	
SP 60	Other insurer type for same period on file (non "J" or "K"). Partner submits a "J" or "K" insurer type, but Medicare's CWF shows "A" insurer type. Insurer type does not match previously submitted insurer type. **Note**: Edit only applies to MSP codes. A - Working Aged B - ESRD EGHP G - Disability EGHP	X	
SP 61	Other insurer type for same period on file ("J" or "K"). Partner submits an "A" insurer type, but Medicare's CWF shows "J" or "K" insurer type. Insurer type does not match previously submitted insurer type. Note: Edit only applies to MSP codes A - Working Aged B - ESRD EGHP G - Disability EGHP	X	

SP EDIT CODES	DESCRIPTION	No Partner Action Required	Agreeing Partner Action Required
SP 62	Incoming termination date is less than MSP effective date. MSP termination date provided must be greater than the MSP effective date. The Partner sent a termination date prior to the MSP effective date. This edit occurs when a Partner fails to note CMS' modification of the Partner's MSP effective date to correspond with the commencement of the Medicare entitlement date. The Partner should go back to its previous response file and identify the correct MSP effective date for this record. If the termination date is earlier than the MSP effective date on the previous response file, this indicates that there was no MSP and the Partner should send a transaction to delete the record.	X	
SP 66	MSP Effective Date is greater than the Effective Date on matching occurrence on Auxiliary file. SP 66 occurs when the Effective Date on the maintenance record is greater than the Effective Date on the Auxiliary record to be updated, and Effective Date plus 30 is greater than "+30."	X	
SP 67	Incoming Term Date is less than posted Term Date for Provident. SP 67 occurs when the Termination Date on the maintenance record is less than the Termination Date on the Auxiliary record that is to be updated.		
SP 69	Updating contractor number is not equal to the header contractor number. CMS assigns the contractor number.	X	
SP 71	Attempting to change source code P-S. Internal CMS use only.	X	
SP 72	Invalid transaction attempted. Internal CMS use only.	X	
SP 73	Invalid Termination Date/Delete Transaction attempted. Internal CMS use only. SP 73 occurs when a FI or Carrier attempts to change a termination date on an MSP Auxiliary record with an 'I' or 'Y' Validity Indicator that is already terminated, or trying to add a Termination Date to an "N' record.	X	
SP 74	Invalid - cannot update 'I' record. SP 74 occurs when a contractor submits a transaction to update/change an 'I' record. Internal CMS use only.	X	

SP EDIT CODES	DESCRIPTION	No Partner Action Required	Agreeing Partner Action Required
SP 75	Invalid transaction. Beneficiary does not have Medicare Part A benefits for the time period identified in the Partner's update file. If there is no Part A entitlement, there is no MSP.		X

Drug Records

For MSP Drug Only or Non-MSP drug or subsidy processing, the COBC will apply similar error checks and provide the results to the Partner in the response file. The SP edits that would be generated as a result of errors on drug records are as follows:

Error Code	Description
*SP 12	Invalid HIC Number. Field must contain alpha or numeric characters. Field cannot be blank or contain spaces.
*SP 13	Invalid Beneficiary Surname. Field must contain alpha characters. Field cannot be blank, contain spaces or numeric characters.
*SP 14	Invalid Beneficiary First Name Initial. Field must contain alpha characters. Field cannot be blank, contain spaces, numeric characters or punctuation marks.
*SP 15	Invalid Beneficiary Date of Birth. Field must contain numeric characters. Field cannot be blank, contain spaces or alpha characters. Day of the month must be correct. For example, if month = 02 and date = 30, the record will reject.
*SP 16	Invalid Beneficiary Sex Code. Field must contain numeric characters. Field cannot be blank, contain spaces or alpha characters. Acceptable numeric characters include the following: 1 = Male 2 = Female
*SP 19	Invalid Transaction Type. Field must contain numeric characters. Field cannot be blank, contain alpha characters or spaces. Acceptable numeric characters include the following: 0 = Add Record 1 = Delete Record 2 = Update Record
*SP 24	Invalid Coverage Type. Field may contain alpha numeric characters. Field cannot be blank. Applicable values are: A, J, K, U, V, W, X, Y, Z, 4, 5, 6 for MSP layout; U, V, W, X, Y, Z, 4, 5, 6 for Non-MSP layout.

Error Code	Description
*SP 31	Invalid Effective Date. Field must contain numeric characters. Field cannot be blank, contain spaces, alpha characters or all zeros. Number of days must correspond with the particular month.
*SP 32	Invalid MSP Termination Date. Field must contain numeric characters. Date must correspond with the particular month – CCYYMMDD. For example, 02/27/1997 is acceptable, but not 02/30/1997. Cannot be earlier than the MSP effective date. If there is no termination date (coverage is still active), must use zeros (not spaces) in this field.
*SP 34	Invalid Subscriber First Name. Field may contain alpha characters. If field is not used, field must contain spaces. Field cannot be blank or contain numeric characters. Only alpha characters used when subscriber is identified.
*SP 35	Invalid Subscriber Last Name. Field may contain alpha characters. If field is not used, field must contain spaces. Field cannot be blank or contain numeric characters. May use spaces instead of apostrophe. Only alpha characters may be used when subscriber is identified.
SP 49	No valid record exists for delete request. Attempt to delete a nonexistent MSP record will cause a reject.
*SP 52	Invalid patient relationship code
SP 62	Incoming termination date is less than effective date. MSP termination date must be greater than the effective date.

Additionally, COBC will provide specific RX coding errors:

Error Code	Description
*RX 01	Missing RX ID
*RX 02	Missing RX BIN
*RX 03	Missing RX Group Number
*RX 04	Missing Group Policy Number
*RX 05	Missing Individual Policy Number
*RX 06	Missing/Invalid Retiree Drug Subsidy Application Number
*RX 07	Missing Part D Effective date

NOTES: Codes marked with an asterisk (*) are "front end" consistency edits. These codes show conditions on the face of the record that are unrecognizable or unallowable for that field.

Codes that do not have an asterisk (*) show discrepancies that result from information on the submitted record conflicting with or not matching the information on CMS's Systems.

V. The VDSA Implementation Questionnaire

The last item discussed in this section is the *VDSA Implementation Questionnaire*. It is not a file layout like those above. Instead, the Implementation Questionnaire is a simple data set that provides information to be used to assure both the VDSA partner and CMS that agreement on essential operational questions has been reached. VDSA partners must complete and return a copy of this document to CMS with their signed VDSA. The Employer and Insurer versions of the Questionnaire are available on the VDSA Web site, www.cms.hhs.gov/medicare/cob/vdsa/default.asp .

SECTION C: WORKING WITH THE DATA

I. Obtaining a TrOOP Facilitation RxBIN or PCN to Use with Non-MSP Records

VDSA partners will need to obtain a TrOOP Facilitation RxBIN or PCN to route claims through the TrOOP Facilitator. The TrOOP Facilitation RxBIN or PCN are routing numbers used to flag claims for coverage supplemental to Medicare Part D that will be paid by VDSA partners or their agents. As it is being routed to the pharmacy, the TrOOP Facilitation RxBIN or PCN will enable the TrOOP Facilitation Contractor to identify a Part D supplemental claim, capture it, and transmit the supplemental paid claim amount to the appropriate Part D Plan to support the Plan's TrOOP calculation responsibilities. To route these claims through the TrOOP Facilitation Contractor, partners may use a separate and unique RxBIN by itself, or a unique PCN in addition to their existing RxBIN.

The organization that issues the original RxBIN is the American National Standards Institute, or ANSI. ANSI can be contacted through its address: www.ansi.org.

A different organization, the National Council for Prescription Drug Programs (NCPDP) issues the Processor Control Number, or PCN. For TrOOP routing you can use a new or additional PCN in lieu of an additional RxBIN. The NCPDP can be contacted through its Web address: www.ncpdp.org.

II. Testing The Data Exchange Process

Overview: Before transmitting its first "live" (full production) input file to CMS, the partner and CMS will thoroughly test the file transfer process. Prior to submitting its initial MSP and Non-MSP Input Files, the partner will submit a test initial MSP Input File, a test TIN Reference File, and a test initial Non-MSP Input File to CMS. CMS will return a test initial MSP Response File and a test initial Non-MSP Response File. CMS will correct errors identified by CMS in the partner's test files. Testing will be completed when the partner adds new enrollees in test update MSP and Non-MSP Input Files, CMS clears these transmissions, and the partner and CMS agree all testing has been satisfactorily completed.

Details: The partner and CMS will begin testing as soon as possible, but no later than one hundred and eighty (180) days after the date the VDSA is in force. The population size of a test file will not exceed 1000 records. All administrative and technical arrangements for sending and receiving test files will be made during the "Preparatory Period" (see "Terms and Conditions," Section A, of the VDSA).

Testing MSP and Non-MSP records: The test file record layouts used will be the regular MSP and non-MSP record layouts. Data provided in test files will be kept in a test environment, and will not be used to update CMS databases. Upon completion of its review of a test file, CMS will provide the partner with a response for every record found on it, usually within week, but no longer than forty-five (45) days after receipt of the test file. After receiving the test Response File in return, the partner will take the steps necessary to correct the problems that were reported on it.

In order to test the process for creating an Update File, a test "Update" shall be prepared by the partner, to include data regarding individuals identified in the Test File. The partner shall submit the test Update, and an updated TIN test Reference File, within ninety (90) days after receipt of the test Response File. The test Update File shall also include an agreed upon number of newly reported Covered Individuals ("adds") that were previously sent to the partner, previously Covered Individuals who have become Medicare eligible as reported by CMS in its Response File to the Test File ("adds"), changes in status as an Active Employee and GHP coverage for Covered Individuals identified in the Test File ("updates"), and deletions for individuals who were erroneously included on the Test File ("deletes"). Upon completion of its review of the test update, CMS shall provide to the partner a Response for every record found on the Test Update File. CMS shall provide a test Update Response File to the partner, usually within with a week, but no longer than forty-five (45) days after receipt of the partner's Test Update File.

After all file transmission testing has been completed to the satisfaction of both the VDSA partner and CMS, the partner may begin submitting its regular production files to CMS, in accordance with the provisions of Sections B through E of the VDSA.

Testing Non-MSP Query Only HEW Files: The partner will provide CMS a test file of the data elements in Attachment F, the Non-MSP Query Only HEW Input File. The HIPAA mandates that partners must be able to transmit and receive HEW "wrapped" Query Only files following the HIPAA 270/271 (Health Care Medicare Entitlement/Benefit Inquiry and Information Response) transaction code set rule and standards. See Section A, II above for more details regarding HEW wrapped files.

The Query Only HEW Input Test File shall contain a maximum of 1000 records of actual data on Covered Individuals. The Test File will allow CMS to review the data prior to receiving the partner's first Covered Individual File submission and identify any defects. The partner will provide this Test File to CMS as soon as possible, but no later than one hundred and eighty (180) days after the date the VDSA is in force.

After processing the Test File, CMS will provide to the partner a Response File identifying those Covered Individuals that have Medicare coverage, and those Individuals not found in the database. CMS will return the Response File to the partner within forty-five (45) days of receipt of the Test File. CMS has the right to request that the partner submit another Non-MSP Query Only HEW Input Test File if CMS finds it necessary. After both the partner and CMS are satisfied with the results of the testing, the partner may begin submitting regular production files to CMS, in accordance with the provisions of Section D, 4 of the VDSA.

III. Transaction Types: Definitions of "Add," "Update" And "Delete"

From time to time a VDSA partner will have to update MSP and non-MSP information it has previously supplied to CMS. To effect any such changes the partner will use the MSP or Non-MSP Input File (see Section I, A).

There are two important conditions that apply throughout this section:

- The only record "Action Type" that will never have an "Add," "Update," or "Delete" Transaction Type applied to it is an 'N' Record.
- Files submitted subsequent to the first production files (the initial Input Files) are deemed Update Files.

Add: An Add is a new data set. It is a new record of coverage information the partner gives CMS that CMS has never posted to its database. The Update File is used to "add" an individual to a CMS database.

Example: Mr. John X. Smith has not yet been included on an Input File. Although he had health insurance as a covered benefit through his employer, Mr. Smith was not yet 55 years of age (the minimum age of Active Covered Individuals that CMS requires to be reported on the MSP Input File). Mr. Smith reaches age 55. Consequently, in a succeeding Update File a record for Mr. Smith is added to the existing database, using an "Add" Transaction Type.

Example: Information about Mr. John Jones, an Active Covered Individual, was included on a previous Update File as an "add," but the partner did not include enough of Mr. Jones' required personal identification data elements. CMS could not determine whether the name and SSN submitted belonged to a Medicare beneficiary, and so this attempt to add Mr. Jones was rejected. With its next Update File, the partner resubmits Mr. John Jones' information (in an "Add" record) and now includes enough data elements for CMS to confirm that he is a beneficiary. NOTE: If rejected again, the record would continue to be submitted as an "add" until a), the partner received a response file from CMS indicating the individual is a Medicare beneficiary or 'b'), the individual no longer satisfies the definition of Active Covered Individual.

Update: A change to a subset of the existing data in a Covered Individual's record that has already been posted to CMS. An Update changes current information about an individual that is already in a CMS database.

Example: In January, a partner sent an "add" record for an Active Covered Individual identified as a Medicare beneficiary, and an MSP record was created and posted for the individual. On July 15th, the individual stopped working and retired. The partner sends this "update" to CMS in the next Update File, which will result in an indication that Medicare is now the primary payer – it changes a formerly open-ended termination date to a July 15 termination date.

Example: The partner provided CMS an "add" record for Mr. John Smith that was accepted by CMS. However, the partner did not originally include some of the non-required data elements such as the "Rx Toll-free Number." The partner subsequently obtains the Rx Toll-free Number for Mr. Smith's record and resubmits the original record with the additional information to CMS. This information would be noted as an "update" Transaction Type on the record.

Delete: Removal of a record that was erroneously sent to and subsequently processed by CMS. A Delete removes all erroneous information about an individual from an existing CMS database.

Example: A record was previously sent to CMS stating that a GHP was a primary payer based on current employment status. Recently the partner discovered that the individual did not have current employment status and that Medicare should have been a primary payer. The partner sends this information in the next update tape and CMS "deletes" the incorrect record from its files.

Matching Partner Data with CMS Data: To add a new beneficiary record, or change one that already exists, certain data elements supplied by the VDSA partner must match data CMS already has.

"Add" Records: Establishing Medicare Entitlement Using Matching Criteria.

In CMS's personal identification matching process, we first look for a valid Medicare Health Insurance Claim Number (HICN). If there is no HICN or the HICN does not match to a known Medicare beneficiary, we then look for a valid Social Security Number (SSN). If the SSN results in a match, we will provide you with the beneficiary's valid HICN. However, if you provide a HICN and we match that number to a Medicare beneficiary, we can NOT also provide you with a corrected or missing SSN.

For CMS to confirm a Covered Individual's Medicare entitlement, the following minimum set of data elements is always required: The individual's HICN or SSN, plus the following personal information:

- The first initial of the first name;
- The first 6 characters of the last name;
- The date of birth (DOB);
- The sex code.

CMS uses this personal information to match and validate the Medicare entitlement data submitted on your record with the person assigned the HICN or SSN in Medicare's database. The personal information you submit doesn't have to perfectly match the information on Medicare's database in order for that particular HICN or SSN to be considered a match. CMS uses a scoring algorithm that compensates for things such as keystroke errors or receipt of an incorrect date of birth. But three of the four personal information data elements must match, or it is not considered a match by the system.

When CMS determines that there is a match, on the response record CMS will update any non-matching personal information we received on the input record. The Data Sharing Agreement partner should store this corrected personal data in its own data systems, and from that point forward use it as the individual's official personal identifying information. To ensure that future data updates are accepted by CMS, any updates to that original record should be submitted under the corrected personal information.

"Update" and "Delete" Records: Additional Matching Criteria

Situation: A partner has had a record previously accepted by CMS (the partner received an "01" Disposition Code on the response record from CMS). The partner wishes to update the record previously accepted by CMS by sending an Update record. In addition to the standard Matching Criteria (SSN or HICN, first initial of the first name, first 6 characters of the last name, DOB and sex), for Update records we also match against the effective date of the coverage, the insurance coverage type, and the patient relationship code. If there is not a match on all of them, we treat the record as an "add" and build a new record, while leaving the original record unmodified on CMS's database. If a partner attempts to "delete" a previously accepted record and the fields listed above don't match, the record will error out.

NOTE: In some cases, CMS will convert the originally submitted coverage effective date to the MSP Effective Date. This occurs where the Medicare Part A Entitlement Date is later than the coverage effective date submitted by the partner. When attempting to update or delete a record where CMS changed the coverage effective date to the MSP effective date on the response record, the partner should submit the effective date previously provided by CMS on the response record.

IV. Protocols for 'D,' 'S' and N' Records

'D' – Other Drug Coverage Reporting for TrOOP Record and Response

The 'D' Action Type in either an MSP or a Non-MSP Input File signals that the record contains information about an individual's prescription drug benefit coverage.

'D' records will require all of the standard matching criteria required in an 'N' record. ('N' records are described at the end of this section, below.) In addition, in a 'D' record VDSA partners should also anticipate providing:

- *Group Health Plan Number* – Number assigned by claim processor identifying the Group Health Plan.
- *Policy Number* – Plans are required to populate this field if the coverage type is V, Z, 4, 5, or 6.
- *Effective and Termination Dates* – These fields are populated in the same way they are on the MSP file.
- *Plan ID* – This field is populated in the same way as on the MSP file.
- *Rx ID* - This is the ID for the individual's drug coverage. This may be the same as the hospital/medical individual ID. This field is required when the coverage type is U, W, X, and Y.
- *Rx Group* - This is the group policy number for the drug coverage. This may be the same as the hospital/medical group policy number.
- *Rx BIN* - Pharmacy Benefit International Identification Number used for pharmacy routing. All network pharmacy payers have a BIN. This field is required when the coverage type is U, W, X, and Y.
- *PCN* - Pharmacy Benefit Processor Control Number used for pharmacy routing. Some, but not all, network pharmacy payers use this for more specific routing along with the BIN. This number, if it exists, is required when the coverage type is U, W, X, and Y.
- *Toll-free Number*- This is the toll-free telephone number commonly found on an insurance card. CMS asks for this so that if there is confusion at the point of sale, the pharmacist or the covered individual can call the Plan for assistance.
- *Person Code* – This is the code the Plan uses to identify specific individuals on a policy. It is policy specific.
- *Relationship Code* – Covered Individual's relationship to the Policy Holder.
- *Coverage Type* – The coverage type codes used on the non-MSP file will be consistent with those used on the MSP file, but not all MSP file coverage types

will be relevant. CMS needs supplemental drug coverage on the non-MSP file. If the partner is describing a network pharmacy benefit the coverage type will be U, W, X, or Y. If the partner is describing a non-network pharmacy benefit the coverage type will be V, Z, 4, 5, or 6.

The 'D' record in the Non-MSP Response File will also contain whatever information was provided in the incoming file, i.e. SSN or HICN, DOB, Rx ID, etc. The Non-MSP Response File will also contain the Rx Disposition Code and Rx Error Codes that will be contained in the MSP Response record for the same reasons and according to the same rules as described in the MSP File section above.

'S' – Employer Subsidy Enrollment File Sharing Record, and Response

Current regulations specifically authorize the use of a VDSA as an alternative method of providing retiree drug subsidy enrollment files to the RDS Contractor. After enrollment with the RDS program an employer can use the VDSA program for its necessary data transfer and management of enrollment files with the RDS Center. Employers wishing to receive the Employer Subsidy for retiree drug coverage must submit an initial application to the RDS Contractor, a requirement separate from the VDSA process. For more information about the employer subsidy please visit: http://rds.cms.hhs.gov/.

As part of the application process, the employer must send an initial enrollment file of all retirees and dependants for whom they wish to claim the subsidy. The initial enrollment file will be followed by regularly scheduled update files containing adds, updates and deletes.

VDSA partners submitting initial enrollment files and subsequent update files for the Employer Subsidy may opt to do so as part of their regular quarterly VDSA filing using a Non-MSP Input File with the 'S' Action Type. 'S' records require the same data elements required for 'D' records, with the addition of the RDS ID, a data element the RDS Contractor will assign to an employer at the start of the application process.

The COBC will send S' records directly to the RDS Contractor for processing. The RDS Contractor will determine whether the covered individuals included on the file are eligible for the Subsidy (Part D eligible but not enrolled). On a response, the RDS Contractor will indicate whether a covered individual was accepted (eligible to be included as part of the employer's subsidy population) or rejected. In most situations these responses will be populated by the RDS Contractor, and the contractor will return whatever information was included in the incoming (input) record, as well as the disposition code. Using the Non-MSP Response layout the RDS Contractor will transmit a response to COBC, and the COBC will then populate the RDS response record with Medicare Part A, B and D Entitlement information. The COBC will then return the completed response file to the partner, as a regular VDSA Non-MSP Response File.

Prior to transmitting the Non-MSP Response File back to the VDSA partner, when COBC receives responses from the RDS Contractor it will screen those responses for

covered individuals who do not qualify to support an employer drug subsidy because they are enrolled in Part D. These individuals will be considered to have other drug coverage relevant to the facilitation of Part D. COBC will change the Action Type of these records from S' to D' and apply them to the MBD in the same way a record originally submitted as a 'D' record is. Partners will then receive back a new 'D' response for that individual's record, including all Medicare entitlement history included in Type 'D' and 'N' responses. The Non-MSP Response File includes fields for the original Action Type and the COBC Action Type when it has been changed from 'S' to 'D' Partners will be required to submit adds, updates or deletes for records changed to 'D' as if they had originally submitted them as a 'D' Record Type.

'N' – Non-Reporting Query Record and Response

Non-MSP Input Files with an 'N' Action Type (that is, a "query only" filing) will require the following *minimum* data set: HIC Number (HICN) or SSN, last name, first initial, date of birth, and sex. All are included as part of the current Non-MSP Input File. In response, CMS will provide the Medicare Part A and B entitlement information it now provides in other non-MSP responses, as well as the new Medicare Part D entitlement information, which is described above in the Non-MSP Response File layout.

Note that an 'N' Action Type (a "query only" input file) includes and is related to information about drug coverage benefits. If a partner wishes to submit a "query only" file not accompanied by information about drug coverage, the file type to use is the Query Only HEW Input File (see A, 2 above).

V. Using BASIS For Queries

When a partner has an immediate need to access Medicare entitlement information, BASIS – the Beneficiary Automated Status and Inquiry System – permits a partner to make a limited number of on-line queries to CMS to find if it is possible that an individual is eligible for or enrolled in Medicare. Using a private, Web-based host, the VDSA partner can use BASIS to access the MBD up to 200 times a month. Access to BASIS is contingent on the partner having submitted its Initial MSP and Non-MSP Input Files and its most recent MSP and Non-MSP Update Files during its last quarterly production cycle.

In overview, BASIS operates as follows:

1. CMS (through its designated contractor) assigns each partner its own personal identification number. This number is delivered to the designated VDSA contact persons within 30 days of submission of the partner's initial MSP and Non-MSP Input Files (see Sections I, A and I, C, above). At this time, the partner will also receive information concerning the designated telephone line to be used for the BASIS application.

2. CMS shall notify the partner when the BASIS application is operational and will provide detailed instructions on how to use the BASIS application.

3. The partner will dial a designated telephone line to access the BASIS application, using its assigned EPIN. For each Covered Individual for whom the partner is requesting Medicare entitlement information, the partner will enter the following data elements that identify the subject of the query:

   - Social Security Number
   - Last Name
   - First Initial
   - Date of Birth
   - Sex
   - HIC Number (optional)

4. CMS will post the results of inquiry(s) to BASIS within forty-eight (48) hours after the partner submits its inquiry(s) to the BASIS application.

SECTION D

FREQUENTLY ASKED QUESTIONS

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General

Q1: Why is a Voluntary Data Sharing Agreement (VDSA) beneficial for an Insurer?

A1: **A VDSA is beneficial to an Insurer because it allows the Insurer and CMS to effectively and efficiently coordinate health care benefit payments in support of an Insurer's obligations under Medicare Secondary Payer (MSP) laws and implementing regulations. The VDSA process provides a way for an Insurer to report, electronically rather than manually, its GHP data to the CMS on a regularly scheduled basis. It prevents an Insurer from making mistaken secondary payments when the Insurer should pay primary in support of its obligation to notify Medicare when it has made a primary payment for services that the Insurer should have made. It also allows for the flow of accurate and timely information to ensure that health care claims are paid correctly.**

Q2: How does the VDSA process work generally? What is entailed in this data sharing arrangement?

A2: **The VDSA process is a periodic/ scheduled electronic exchange of Medicare entitlement, group health plan (GHP), and individual policy coverage information that enables the CMS and employers/insurers to determine**

primacy payment order and to appropriately coordinate health care benefits. GHPs provide eligibility data for policy holders/employees and their spouses. In exchange, CMS provides Medicare eligibility information for identified Medicare individuals.

Q3: Give me a high level explanation of the kinds of health plan coverage information you are capturing to coordinate benefits between my health plan and Medicare?

A3: **The MSP file is used to report hospital, medical and drug coverage that is primary to Medicare (including but not limited to active covered workers and their covered spouses and dependents). Medicare will be the secondary payer.**

The Non-MSP File is to capture only drug coverage that is secondary to Medicare (covered retirees and their covered spouses and dependents). We need this other drug coverage data to help the Part D plans calculate the beneficiaries' True Out-Of-Pocket costs and to assist pharmacies bill in the correct payer order at the point of sale.

Q4: My company is one of the original (legacy) VDSA partners. Will we need to sign and use the "new" VDSA starting in 2006?

A4: **Yes. Part D has made it necessary for us to revise our VDSA reporting requirements. All VDSA partners using pre-MMA VDSA documents (legacy partners) are expected to have migrated to all of the "new" VDSA record layouts by March 31, 2006.**

Q4: What is the purpose of BASIS?

A4: **The Beneficiary Automated Status and Inquiry System (BASIS) allows VDSA partners to make a limited number of on-line queries to CMS (up to 200 times a month) when the partner needs access to Medicare entitlement information prior to the next scheduled data exchange. To use, the partner must have submitted initial MSP and Non-MSP Input Files, and its most recent MSP and Non-MSP Input Files during the last production cycle.**

Q5: Please provide Internet resources I can go to for additional information about the VDSA program for employers?

A5: **For employers please visit the Coordination of Benefits (COB) page of the CMS Web site located at:**

http://www.cms.hhs.gov/medicare/cob/employers/emp_vdsa.asp.

For insurers please visit the Coordination of Benefits (COB) page of the CMS Web site located at:

http://www.cms.hhs.gov/medicare/cob/insurers/in_vdsa.asp.

TERMS OF THE AGREEMENT

Q1: I'm not sure I understand the definition of Active Covered Individual, and who I should include on the MSP file?

A1: I**n addition to the minimum MSP reporting requirements in the VDSA, CMS is asking you to include all of the individuals on the MSP Input File covered by your group health plan (GHP) for whom, if they had Medicare, Medicare would be the secondary payer to their GHP benefits. Although many of the definitions in the Agreement reference legal cites, they aren't meant to be restrictive, but instead represent the minimum data requirements for purposes of MSP reporting under the terms of the VDSA.**

Q2: How flexible is CMS in administering the terms of the Agreement?

A2: **Although the Agreement is a standardized document, CMS will be flexible in administering the implementation and ongoing operational terms of the Agreement. CMS's ultimate goal is to ensure timely and accurate coordination of benefits with our VDSA partners. To achieve this goal, CMS has built flexibility into the VDSA process to enable all of our VDSA partners to meet their obligations under the Agreement as efficiently and accurately as possible within a time frame that is mutually acceptable to CMS and our many, varied VDSA partners.**

Q3: The definition of Active Covered Individuals in the Agreement seems restrictive. What about ESRD beneficiaries who are not working and still in the 30-month coordination period? Don't you want to know about these individuals? Can we include them on the MSP Input File?

A3: **Yes. Although the definition of Active Covered Individual in the Agreement references the definition of "Active" in 42 C.F.R. § 411.104, there are MSP situations where the covered individual is not covered via their "Active" work status, such as the 30-month ESRD coordination period. The definition of an Active Covered Individual in the Agreement is not meant to be all-inclusive. Instead, it sets the minimum MSP reporting requirements the VDSA partner must meet to be considered compliant with the terms of the Agreement. Field 20 of the MSP Input File - "Employee Status" - allows you to tell us whether your plan is primary for the individual because of "1. - Current Employment Status" or "2. - Another Reason." Non-working ESRD beneficiaries would be entered as "2."**

Q4: Although the VDSA asks for Active Covered Individuals at least 55 years of age, we provide family coverage to one of our active workers who is only 39 years old and we are fairly certain that his wife, who is also 39 years old, has Medicare due to disability. Can we include these individuals on the MSP Input File?

A4: **Yes. Although the minimum data set we require on the MSP Input File is for all Active Covered Individuals and their covered spouses and dependents aged 55 and over, we encourage VDSA partners to include Active Covered Individuals younger that 55 where they are fairly certain MSP status applies.**

Q5: Since there can be MSP situations for workers younger than 55, why do you only ask for information about beneficiaries who are at least 55?

A5: **CMS has found that 97% of MSP situations occur in the Medicare beneficiary population aged 55 and older. To reduce the processing burden on our VDSA partners, some of which have a generally younger enrollee population, CMS does not require a full file of all Active Covered Individuals on the MSP Input File. VDSA partners can include younger that 55 year old Active Covered Individuals on their MSP Input File if they wish, but the minimum requirement is that they include all Active Covered Individuals aged 55 and over.**

Q6: We are an existing VDSA partner, and we send you data on plan membership for people age 40 and over. Can we add to that and send additional membership under age 40 where we have identified ESRD diagnosis on claims and identified possible disability? This would be for exchanges later in the year. Is this something we can do? If so, do we have to have the agreement formally changed?

A6: **That is not a problem, and in fact if you suspect younger people might be entitled to Medicare we would encourage you to include them on your file. The VDSA does not need to be changed formally if you add these individuals who you suspect may have Medicare. We will follow normal processing procedures in order to determine a match for the records that you submit and will pass back a response letting you know whether an individual was matched to Medicare entitlement.**

Q7: Other than stating that files can be exchanged quarterly with the option of exchanging non-MSP files on a monthly basis, there is no mention of the actual reporting schedule we would use?

A7: **The COB contractor will work with each VDSA partner during the Preparatory Period to set up a reporting/data production schedule.**

Q8: What does CMS consider to be a successful completion of the testing process?

A8: **At a minimum CMS requires the VDSA partner to be able to (1) submit an initial test MSP and Non-MSP Input File that can be processed to the satisfaction of the COB contractor, (2) receive and process a test MSP and Non-MSP Response File from the COB contractor, and (3) be able to submit**

a test Update MSP and Non MSP file to the COB contractor. We have delegated the authority to determine whether or not the VDSA partner has successfully completed the testing process to the COB contractor.

Q9: How long does the testing process take?

A9: **Testing can begin as soon as a VDSA is executed by both Parties, and it occurs on a scheduled weekly basis. Under ideal circumstances each testing cycle takes about a full week before the VDSA partner can be ready to submit the next test file. Testing will take place at the VDSA partner's preferred pace and can take a month or more to complete, depending on how quickly the VDSA partner can gather the necessary resources to meet the implementation requirements. VDSA partners should note that CMS's goal throughout the testing and implementation process is to ensure that the VDSA partner's first production file is as accurate as possible. The accuracy of data on the first production file is more important than the timeliness of that first production file.**

Q10: Are there any implementation or ongoing fees charged by CMS to VDSA partners.

A10: **There are no fees charged by CMS to participate in the VDSA process**.

Q11: Full production of the new VDSA cannot begin until November 15, 2005, but we were required to submit our enrollment data to RDS by September 30, 2005. How did this process work?

A11: **Partners were able to submit 'S' records using the Non-MSP File layout to meet the RDS deadline of September 30, 2005. Although full production of the new VDSA process could not begin until November 15, 2005, we began accepting skeletal Non-MSP files containing only 'S' records on September 1, 2005. They were passed on to the RDS Center for processing. Responses were generated by RDS and passed back though the VDSA process to the partner. The RDS responses included RDS Disposition and Edit codes. For files that are submitted prior to November 15, 2005, the COB contractor will do nothing with the RDS response file except pass it back to you.**

On November 15, 2005, when we go live with full VDSA production files, we will begin looking at the RDS response file and editing it for records rejected by RDS because the beneficiary was enrolled in Part D. That is also when we will begin populating the 'S' response records with Medicare Entitlement Data.

Q12: In addition to various physical media, such as CDs and tapes, and the ability to send data via a leased T-1 line, what Secure FTP CMS protocol will VDSA partners be offered?

A12: **CMS will utilize Sterling Commerce's Gentran Integration Suite 4.0 B2B for Multi-Enterprise Collaboration (GIS B2B Suite), via the internet or an existing T-1 line. CMS is currently testing with several VDSA partners with the goal of allowing full implementation in fall 2005. For more information about the Sterling product visit their Web site at http://www.sterlingcommerce.com/PDF/About/GIS40_01April.pdf#page=1**

Q13: We are an insurer representing hundreds of plan sponsors (employers) and do not know whether to submit individuals on either the MSP Input File or the Non-MSP Input File. We would like to develop information regarding the Active or Inactive work status of all of our enrollees. Can we use the "N" record process to query for Medicare Entitlement data so that we can focus our development activities toward the small percent of our enrollment population that has Medicare?

A13: **Yes, under two conditions. First, CMS expects all new VDSA partners to fully test their MSP and Non-MSP file submission processes as required in the VDSA before we will allow for the exchange of any production data. Second, when CMS provides Medicare entitlement data in response to an 'N' query record, CMS expects the VDSA partner to complete development regarding that individual within a commercially reasonable time, and to begin reporting on that individual, where applicable, using either the MSP Input File or as a 'D' record on the Non-MSP file. Failure to meet these two conditions will result in termination of the Agreement by CMS.**

Q14: Why do you ask for the employer and insurer Tax Identification Numbers (TINs)? How are they used?

A14: **We ask for TINs and a TIN reference file for several reasons:**

First, TINs are the primary employer and insurer identifier CMS uses in many of its coordination of benefits processes and in its recovery processes. The Debt Collection and Improvement Act of 1996 required CMS to collect TINs of potential debtors and provide them to the Treasury Department as part of its debt recovery process. Because of this requirement to use the TIN, CMS has since made the TIN the primary identifier for all potential debtors to Medicare. It is also provides for a more efficient method of coordinating benefits on the "front end."

Second, not having the TIN increases costs to both CMS and Treasury and can lead to an inefficient recovery process that adds administrative burden to the debtor. For example, to reduce the administrative expenses associated with debt recovery for both CMS and the debtor, CMS routinely uses the TIN number to aggregate demands for recovery of mistaken Medicare payments. Without the TIN, CMS cannot aggregate demands.

Third, collecting TIN numbers on each record instead of the actual name and addresses reduces the size of each record and speeds up the processing of the millions of VDSA records we receive.

Fourth, TINs allow our VDSA partners to easily manage the addresses they provide to CMS for benefit coordination. Example: Large employer XYZ Inc. has a VDSA with CMS. They report on 200,000 covered lives under 50 TINs representing the parent company and its many subsidiaries. Since all health care benefits are coordinated out of one address, they submitted their TIN reference file with the same address for every TIN. If that address changes, they only have to submit a new TIN file and not update every single individual record. The TIN file is much smaller and easier to maintain than the tens of thousands of individual records.

Finally, for employers that have signed VDSAs, the TINs you provide on your VDSA is what allows CMS to suppress mailing of all IRS/SSA/CMS Data Match questionnaires to your organization.

Q15: Would you clarify for me what inactive means. Does this mean inactive as in cancelled members or inactive as in "update file"?

A15: **"Inactive" means that a covered individual is not working. He or she has health insurance benefit coverage but does not meet the definition of an "Active" (working) covered individual. In the VDSA process the "Inactive File" is where Retiree/Supplemental Drug data is reported.**

Q16: We are currently in the process of getting a signed agreement with CMS to participate in the Voluntary Data Sharing Agreement process. Do we need to have this agreement in place before a certain deadline?

A16: **The VDSA, which provides an optional way for employers to provide the drug subsidy contractor with enrollment information as well as enabling you to fully coordinate all group health plan benefits with Medicare, must be signed before we can begin accepting files. We began executing new agreements the second week in August 2005. If you are not already on our distribution list, we can add your contact information. Look for e-mails from COBVA@ghimedicare.com regarding the VDSA program. We host occasional VDSA informational conference calls and will continue to do so. We also provide new and updated written materials as they are developed.**

Q17: For accounts that allow subscribers to cover a parent or in-law and in the working aged provisions, does CMS consider these situations as any different than covering a spouse? It's an active coverage. The disability provision of the MSP rules has the term “family member” but the working aged provision states “spouse.”

A17: T**he working aged rules only apply to the employee and spouse, but the disability rules apply to family, including parents & in-laws. For an excellent detailed summary of the MSP rules in fairly plain language, you can download a copy of the IRS/SSA/CMS data match instruction booklet from the COB Web site.**

Q18: Will current VDSA partners need to execute a new VDSA, even though we already have an existing VDSA in place?

A18: **Yes. Because the Medicare Modernization Act (MMA) added the new Medicare Part D pharmacy benefit, the data management requirements of the new drug benefit have made it necessary for us to revise the VDSA in a number of areas. One such revision involves the Retiree Drug Subsidy and its attendant information exchange requirements. Consequently, beginning in September 2005 all of our existing VDSA partners were asked to sign the new agreement.**

Q19: We are a large insurer and do not know the size of all of the employers in each group, and we do not know about the active working status of all of our covered individuals. Is there anything CMS can do to assist us in our development efforts?

A19: **It is critical to the success of the VDSA program that the VDSA partner knows which of their covered individuals should be included on either the MSP Input File or the Non-MSP Input File. Entities that need to perform significant development (coverage analysis) in order to provide complete VDSA files can query for Medicare entitlement information on their Covered Individuals using the 'N'" action type on the Non-MSP Input File and then focus further development efforts on only those individuals that are entitled to Medicare. CMS expects such development to be completed within a reasonable amount of time and to begin seeing those individuals being reported on either the MSP File or the Non-MSP file, as applicable.**

Q20: What functions does the non-MSP record layout support?

A20: **VDSA partners can use the non-MSP record layout for satisfying the reporting requirements of the employer subsidy to the RDS Contractor; for reporting non-Medicare other drug coverage information to support the TrOOP facilitation process; and for non-reporting purposes to obtain Medicare entitlement information. These various purposes are identified on the input record by action type, namely the 'S', 'D'and 'N' records.**

RECORD LAYOUT AND FILE SUBMISSIONS

Q1: We are a large employer that is also self-insured, but we contract with a Third Party Administrator (TPA) to administer our plan benefits. In the MSP Input File you ask for an Insurer TIN and an Employer TIN. Should we use our Employer TIN for both?

A1: **Since you use a TPA to handle the day-to-day administration of your plan benefits, we would suggest that you include your third party administrator's TIN in Field 22 (Insurer TIN). That way we can directly involve both you and your TPA in any Medicare coordination of benefits issues that affect your plan enrollees.**

Q2: I noted in the TIN File record layout that if we don't have or can't get the real TIN of all of the entities related to the Active Covered Individuals we will be reporting on in the MSP Input File, we can supply "pseudo TINs." Can you clarify?

A2: **For some of our larger insurer partners that deal with hundreds and even thousands of employers, getting the TINs from all of them could prove challenging. In order to allow VDSA partners to report all of their Active Covered Individuals as soon as possible, the partner can supply pseudo numeric TINS on records that they don't yet have the real TINs. Pseudo TINs will not be treated like real TINS and utilized for other CMS coordination of benefit and recovery purposes.**

Q3: If we can just make up "Pseudo" TINs, why should a VDSA partner bother developing for the real TINs?

A3: **Please refer back to the answer for Question 14 on Page 78. Pseudo TINS will not be used to perform any of the functions mentioned in Question 14 regarding CMS front-end coordination of benefits and recovery processes. Most importantly, we cannot suppress IRS/SSA/CMS Data Match Mailings to employers unless we receive their real TINs via the VDSA.**

Q4: We are a large employer with 37 TINs for subsidiaries scattered across the country, but all of our health care benefits are administered out of one location. Since you ask for the addresses associated with our health care benefits administration, can we use the same address on every TIN?

A4: **Yes. That is the benefit of the TIN reference file. It allows you to provide us with the one address to which you would want CMS or any of our mutual partners involved in health care coordination of benefits to direct their inquiries. So, for your example, in addition to containing the appropriate insurer TINs, your TIN reference file would include thirty-seven employer TINs, each with the same address.**

Q5: Throughout the proposed layouts, there is a field for HIC Number. In some of the layouts it states that the HIC is not required if the SSN is provided. This is not explicitly stated in other layouts. Please confirm that SSN is an acceptable substitute for HIC throughout all the layouts.

A5: **We always need either the HIC Number (HICN) or the SSN. Having one of these numbers is necessary in order to perform the matching process that determines which of the Covered Individuals that you submit are also entitled to Medicare. We can accept both numbers if you have them and we encourage you to pass both in case one contains a keystroke or other error.**

Q6: The Non MSP (Inactive) File Process has an action type code field with values of 'D' for other drug coverage for reporting for TrOOP, and 'S' for Employer Subsidy enrollment file sharing and 'N' for the non-reporting Query function. Please clarify when a partner would pass the action type code 'N' (non-reporting).

A6: **The 'N' record is a query record where you are merely asking for Medicare entitlement information. We do not store that information for our future use, which is why we call it a non-reporting record.**

Q7: Which coverage type would an Insurer be classified under if the Insurer offers an integrated package of benefits with medical, surgical, pharmacy coverage and most drug claims are administered and adjudicated at the point of sale electronically?

A7: **The Insurer would carry a coverage type of 'W'.**

Q8: What should we do for records that do not have the SSN?

A8: **If you do not have the SSN or a HICN, you should not send the record. We use either number to match the record you submit to Medicare entitlement information, and with no number we can't search for a match. It is very important that you continue to collect the SSN.**

Q9: There are many insurers that do not use the SSN in their subscriber numbers. Are you concerned about seeing the number change?

A9: **Many insurers are no longer using the SSN as a Subscriber/Policy ID and are in the process of converting their members to a new non-SSN ID. That is fine with us, so long as we receive update transactions accordingly. But all of those Insurers who are converting the SSNs still need to collect the SSNs of anyone they cover if they are to coordinate benefits with Medicare. The SSN is our primary way of finding Medicare beneficiaries if you do not have a HICN. Remember, no state laws override the requirements in federal law and Medicare's need for the SSN to support its coordination of benefits activities.**

Q10: Would you clarify for me what inactive means. Does this mean inactive as in cancelled members or inactive as in "update file"?

A10: **"Inactive" means that the covered individual is not working. He or she has coverage but does not meet the definition of an "Active" (working) covered individual. What was referred to in the old VDSA process as the "Inactive File" is where Retiree/Supplemental Drug data will now be reported.**

Q11: The Non MSP (Inactive) File Process has an action type code field with values of ‘D’ for other drug coverage for reporting for TrOOP, ‘S’ for Employer Subsidy enrollment file sharing, and ‘N’ for the non-reporting Query function. Please clarify when a partner would pass the action type code N (non-reporting).

A11: **An ‘N’ record is not used to report any data to CMS for processing, but instead allows the submitter to query CMS for Medicare entitlement information. An ‘N’ action type is used by the submitter for query purposes only. Data submitted as ‘N’ records are not stored or used by CMS.**

Q12: Can we submit ‘N’ records on potential MSP "Active Covered Individuals" as well as for our retirees or other "Non-MSP" covered individuals?

A12: **Yes. You can submit ‘N’ records on any of your plan's Covered Individuals. Because data submitted on ‘N’ records is not used or stored by CMS, you must still submit information about your Covered Individuals where applicable on either the MSP Input File or as a ‘D’ record on the Non-MSP file.**

Q13: We are an insurer representing hundreds of plan sponsors (employers) and do not know whether to submit individuals on either the MSP Input File or the Non-MSP Input File. We would like to develop information regarding the Active or Inactive work status of all of our enrollees. Can we use the "N" record process to query for Medicare Entitlement data so that we can focus our development activities toward the small percent of our enrollment population that has Medicare?

A13: **Yes, under two conditions. First, CMS expects all new VDSA partners to fully test their MSP and Non-MSP file submission processes as required in the VDSA before we will allow for the exchange of any production data. Second, when CMS provides Medicare entitlement data in response to an ‘N’ query record, CMS expects the VDSA partner to complete development regarding that individual within a commercially reasonable time, and to begin reporting on that individual, where applicable, using either the MSP Input File or as a ‘D’ record on the Non-MSP file. Failure to meet these two conditions will result in termination of the Agreement by CMS.**

Q14: What is the difference between the “Relationship Code and the "Person Code?"

A14: **Relationship Code refers to the cardholder, spouse, and dependent; thus, all dependents may have the same Relationship Code. The Relationship Code is independent of the Person Code. Person Codes for family members usually follow a set pattern: Cardholder is always "01"; Spouse is always "02"; dependents are numbered ‘03’ to ‘99’. Usually, the dependents are numbered according to the age of the dependent. The oldest dependent will start at ‘03’. The Person Codes assigned to the dependents within a specific family are not reassigned when an older child is no longer a dependent (as defined by the plan’s coverage rules).**

Q15: As an insurer, we cover employer groups that may have multiple TIN numbers. However, for our purposes they are only one entity. We would like to use only one TIN for the entire company, but that would not coincide with the actual number of TINs the company may have for tax purposes. Is the TIN used just to identify the name/address, or is it actually used to identify the actual taxing entity?

A15: **It is important to provide the TIN for each plan sponsor you do business with, based on their responsibilities under the MSP rules. If there are multiple unrelated employers represented in one group, we would want the TIN and associated address for each employer in that group. If you deal with one plan sponsor that has multiple TINs, such as a large parent company with many subsidiaries, you only need to provide the TIN and address for all of the individuals under the plan sponsor. Even so, we would encourage you to provide as many additional TINs as possible to ensure efficient coordination of benefits.**

Q16: We offer GHP (group health plan) coverage to domestic partners. What relationship code should we use to list a domestic partner? Is he or she considered a spouse?

A16: **Federal regulations do not recognize domestic partners as spouses, but they are recognized as family members. Therefore enter ‘04’ (other) in the field asking for the Relationship Code (MSP Input – Field 12. Non-MSP Input – Field 18.). Under the Working Aged rules, MSP only applies to workers and their spouses, so there is no MSP if the Medicare Entitlement Reason is ‘A’ (Working Aged). However, MSP does apply to domestic partners if the Medicare Entitlement Reason is ‘B’ or ‘G’ (ESRD or Disabled).**

Q17: There are many MSP situations where the Active Covered Individual works for a small employer but is part of a multi-employer plan where another employer sponsor of that plan has more than 20 employees. Do we report these individuals? How do we complete Field 16 (Employer Size)?

A17: **If the individual works for an employer that has less than 20 employees, but is part of a multi-employer plan where another employer in that plan has 20 or more employees, enter '1' (20 to 99 employees) in Field 16 (Employer Size). To ensure that we don't build an incorrect MSP record for someone entitled to Medicare due to disability, never enter "2" (100 or more employees) in this unique situation.**

Q18: We don't have all of the SSNs for all of our covered individuals (and we don't supply HICNs). Should we include them on the file anyway?

A18: **No. Without either the SSN or HICN, do not build a record for that individual. The SSN and/or HICN are the primary numbers we use to look up Medicare entitlement. Without one or both of those numbers, the record will not process.**

Q19: The record layouts ask for the SSN and HICN. We have SSNs but not the HICN. Is that enough information to find Medicare entitlement?

A19: **Yes. To find whether the individual on a submitted record is a Medicare beneficiary we require either the SSN or HICN, first 6 characters of the person's surname, first name initial, date of birth and sex.**

Q20: What if we have the SSN or HICN and not all of the personal identifying information (first 6 characters of the person's surname, first name initial, date of birth and sex) that you need to find Medicare entitlement?

A20: **You should include as much of the personal identifying information as possible. It is often possible to find Medicare entitlement even if not all of the personal identifying information exists or is correct on your record. We use a matching algorithm that accepts a match when at least most of the personal identifying information is correct for that submitted SSN or HICN.**

Q21: I got back a match on one of my records in the response file but the date of birth I originally submitted was changed. Why? Should I store this information?

A21: **This is a situation where the information you provided was enough to make a match to a Medicare beneficiary but where the birth date CMS had on its Medicare Beneficiary Database conflicted with the birth date you submitted. It is very common to receive information that doesn't result in a 100% match but is still accurate enough to be considered a match. This happens for reasons such as keystroke errors, or because your enrollee didn't provide you with completely accurate information at enrollment. We expect you to store the matching criteria CMS provides to you on the response file (first 6 characters of the person's surname, first name initial, date of birth and sex) to better ensure that you will match again when you have to update the same record.**

Q22: I notice you have the option of submitting the Non-MSP file on a monthly basis or a quarterly basis, but that you can only submit the MSP file on a quarterly basis. Why?

A22: **The editing routines used by the Medicare Common Working File (CWF) to process MSP records are very comprehensive. These built-in routines attempt to resolve errors generated when the file is processed. Records that "error out" are recycled/reprocessed for 30 days in an attempt to resolve as many of the errors as possible before the Response file is sent back to the VDSA partner. Records submitted on the Non-MSP file can usually be processed and returned within a week, thus making it possible to offer the VDSA partner the option of submitting the Non-MSP file monthly or quarterly.**

Q23: What are the benefits of submitting the Non-MSP file every 30 days? Every 90 days?

A23: **This is a business decision that each partner will have to evaluate and make on their own. Many entities that will be using a VDSA to submit enrollment files to the RDS contractor wish to submit on a monthly basis, so that they can receive RDS payments on a monthly basis. Others may wish to receive Medicare entitlement data on a more frequent basis and so will submit Non-MSP files on a monthly basis. Conversely, other VDSA partners want to have more time to evaluate the response files and more time to build their next submission files, and thus choose to submit Non-MSP files on a quarterly basis. They are concerned that the extra resources needed to perform a monthly exchange will be cost prohibitive, or they worry that in rushing to meet a monthly deadline, they may be more likely submit erroneous or incomplete data.**

Q24: We do not find a header or trailer record for the Query Only HEW Response File, Attachment G. Did we overlook it – if so, can you point us to the right source? Is it an oversight and there should be one? Is one not needed?

A24: **Attachment G has no header or trailer because for this particular file neither is necessary, and we don't include them with our response. The partners include a header and trailer on the input file since they all send to a common data set destination. The header/trailer allows us to identify the sender so we can route our response back to the correct sender. We always send the response to the DSN specified by the partner.**

Q25: "*The Query Only HIPAA Eligibility Wrapper (HEW) Input File.*" You say that this is a Non-MSP File that is not accompanied by information about drug coverage – it only serves as a query file regarding Medicare entitlement of potential Medicare beneficiaries. Using a CMS-provided program, the VDSA

partner will translate ("wrap") the Non-MSP file into a HIPAA-compliant 270 eligibility query file format.

Can you explain in more detail how this works? Is there more information on this somewhere else?

A25: **If you are not going to be submitting 'D' or 'S' records – you only want to submit a "lookup" or query – you must use this program format because the lack of 'D' or 'S' records makes this an "inquiry only file" – a pure inquiry file. The "HIPAA Eligibility Wrapper (HEW)" program must be applied to all "inquiry only" file exchanges because these particular data transfers are subject to HIPAA privacy regulations. More information about Query Only HEW Input Files can be found in Section C, "Working With The Data," starting on page 64.**

PART D AND VDSAs

Q1: Do you know if Congress extended the MSP laws to the new RDS program?

A1: **No, the MSP laws do not extend to the new RDS program, because beneficiaries enrolled in the RDS program are not enrolled in Medicare Part D. MSP laws are not applicable when the beneficiary is not receiving a Medicare benefit.**

Q2: We have heard that a beneficiary in a Medicare Advantage Plan could have drug coverage within that plan or not. What that means to us is that a beneficiary could have a Medicare Advantage Plan for their equivalent Part A and Part B coverage and could choose a "stand alone PDP" for prescription drug coverage. Is this a correct assumption? If it is, what data elements will help distinguish this? Will a Medicare Advantage Plan with drug coverage have different contract number then a Medicare Advantage Plan without drug coverage? If a beneficiary chooses an MA plan and a separate PDP, it seems to indicate that this situation would deserve two different contract numbers to be sent; one that distinguishes the MA coverage and one that distinguish the Part D coverage. Is this correct?

A2: **§423.30 states that a Part D eligible beneficiary enrolled in an MA Plan must get Part D coverage from their MA-PD unless the Part D eligible enrollee is enrolled in a (1) MA private fee-for-service plan that does not have drug coverage or (2) a MSA plan or (3) if the beneficiary is in a cost plan and does elect the qualified prescription drug coverage under the cost plan.**

So, in our exchange, we will only be providing you with the Part D Plan the beneficiary is enrolled in. These are the scenarios. A beneficiary is in a MA plan for hospital & medical that does not offer drugs, and must enroll in a stand alone PDP: We will provide you with the PDP contractor number,

coverage dates, and premium amounts only. A beneficiary is enrolled in an MA-PD that covers hospital, medical, and drugs: We will provide you with the MA-PD contractor number, coverage dates, and Part D premium amount portion. A beneficiary is enrolled in Parts A & B fee-for-service for hospital and medical (traditional Medicare) and a stand alone PDP for drugs: We will provide you with the PDP contractor number, coverage dates, and premium amount.

In terms of distinguishing between non-Rx MAs & MA-PDs, each plan will have a unique contractor number. By consulting the CMS Web site you will be able to determine which plans do cover drugs.

Q3: I recognize edits that CWF (Common Work File) passes back when editing MSP records for hospital and medical coverage. Where are the MBD (Medicare Beneficiary Database) edits for drug records?

A3: **MBD will not edit drug records. Instead, the COB contractor will perform minimal front-end edits of the data and pass back COB contractor edits (RX Error Codes) of drug records submitted by the VDSA partner, and a Disposition Code from MBD (Rx Disposition Code).**

Q4: Why are there fields labeled Disposition Codes and Rx Disposition Codes? What is the difference between these two codes?

A4: **Hospital/Medical coverage and Drug coverage information are stored on two different CMS databases, thus requiring two sets of Disposition and Error codes. When a record containing hospital/medical and drug coverage comes in, we split the record to process the hospital/medical coverage to the CWF, and the drug record to process to the MBD. When the two sets of information have finished processing, CMS re-combines the data into one response record containing the two sets of Disposition and Error codes. It is possible that a record submitted that contained hospital, medical and drug coverage could successfully process to one database and not the other.**

Q5: Why are you asking for a separate list of the Standard and TrOOP RxBINs and PCNs in the Implementation Questionnaire when we give those to you on the individual record?

A5: **The COB contactor will use that list to perform informal edits of the data submitted on both the MSP Input File and the Non-MSP Input File, to ensure that we are receiving only the Standard RxBIN/PCNs on the MSP Input File and only the TrOOP RxBIN/PCNs on the Non-MSP Input File.**

Q6: Are the RxBIN and PCN required fields on the layout, given that we are submitting for an employer-sponsored plan and not an insurer? If so, is this information that we should obtain from our PBM (Pharmacy Benefit Manager)?

A6: **If the coverage type your plan offers includes a prescription drug benefit that utilizes an electronic pharmacy data network, we require those numbers. Not everyone using a pharmacy network uses a PCN, but everyone using a pharmacy network will have an RxBIN, so the RxBIN is always required when a coverage type of U, W, X or Y is entered in the Input File. The PCN should be supplied if your drug plan uses it. Many plans contract with a PBM to run their drug benefit and, if so, the PBM will be able to supply these numbers to you.**

Q7: The VDSA states that everyone who uses the RxBIN and/or PCN will have to get a separate TrOOP-specific RxBIN and/or PCN. This is to ensure that drug claims are routed appropriately. Do we have to apply for an additional RxBIN or PCN number? Who determined that we have to have two separate RxBINs?

A7: **We needed a method to route Part D drug claim data through the TrOOP Coordinator, one that would work easily within the existing pharmacy EDI networks. A quick and efficient process to obtain claim routing codes already existed, so we chose to adopt it to support Part D TrOOP data management.**

Q8: How do I, as an employer, obtain a TrOOP RxBIN or PCN?

A8: **You will need to instruct whoever is responsible for paying your drug claims electronically at the pharmacy point of sale (your insurer or Pharmacy Benefit Manager) to obtain a TrOOP RxBIN or PCN that will supplement the Standard RxBIN or PCN they already have for your population. (See also "Obtaining an RxBIN or PCN To Use With Non-MSP Records," starting on page 65.)**

Q9: I am an insurer that has signed both a Coordination of Benefits Agreement (COBA) and a VDSA. As far as I can determine, both projects support MMA and Medicare D by requiring the submission of prescription drug coverage information that is secondary to Medicare. Do I have to submit in on one or the other or on both? Does CMS have a preference?

A9: **If you have both a COBA and a VDSA you only need to submit drug coverage information through one of those processes. Therefore, if you have a VDSA and a COBA and decide to report prescription drug coverage information that is secondary to Medicare through your COBA, you would only have to submit coverage information that is primary to Medicare on the VDSA MSP Input File, and you would not have to submit coverage information that is secondary to Medicare on the VDSA Non-MSP Input File.**

Q10: What are the reporting requirements of prescription drug coverage information for payers signing either a COBA or a VDSA?

A10: **Payers that sign a COBA will be required to report Retiree/Supplemental Drug coverage to CMS. Payers that have signed a VDSA with CMS will be required to report Retiree/Supplemental Drug coverage to CMS. Payers that have signed both a COBA and a VDSA have the option of reporting retiree/Supplemental Drug coverage through one process or the other.**

Q11: The CMS is always saying that if a beneficiary signs up for Part D, then shows up on an employer roster, that CMS will notify the employer. This seems to be a coordination of benefits process. So is that happening in a way not connected to the RDS feed? Isn't that basically a COB? Would that not happen without VDSA? Can you speak to that? Must an employer undertake a VDSA to have that level of feedback and reconciliation?

A11: **Everything that RDS offers is available to an employer whether the employer reports enrollment information to RDS directly or via the VDSA. In either case, all employers claiming the subsidy will be notified by the RDS contractor via e-mail when someone enrolls in Part D. One of the additional benefits of using the VDSA is that it allows for a query of Parts A, B, and D entitlement information between submissions via our dial up application called BASIS. RDS will not give you that kind of detail.**

Q12: If an Insurer currently sends you medical information, will you be adjusting the existing file layout to incorporate the additional Rx information requested or is the expectation that the Rx information would be sent on a separate file? If you are adjusting the existing file layout sent by Insurers, do you have a time frame for when the new file layout will be communicated?

A12: **The CMS has revised its existing VDSA to incorporate the changes that are necessary to support the new prescription drug benefit under the MMA. Insurers will be able to submit information via a VDSA or through their COBA, or they may have another entity, such as their PBM submit it. Most PBMs are now familiar with the VDSA process. If you are a PBM would like more information about the VDSA process or have additional questions, you can send them to COBAVA@ghimedicare.com. You can also request to have your organization's name added to our distribution list so that you can receive updated materials and relevant information regarding the VDSA program.**

Q13: Which coverage type would an Insurer be classified under if the Insurer offers an integrated package of benefits with medical, surgical, pharmacy coverage and most drug claims are administered and adjudicated at the point of sale electronically?

A13: **The Insurer would carry a coverage type of 'W'.**

Q14: How do the MSP provisions impact Part D?

A14: **The MSP laws found at 42 U.S.C. § 1395y(b) were extended to Part D in § 1860D-2(a) (4) of the MMA and are applicable to GHP prescription drug coverage according to the same rules that apply to GHP hospital and medical coverage.**

Q15: Is it really necessary for us to send a separate file containing "Drug" (Action Type 'D') records when we will be sending the data for those who are enrolled in Part D on our 'S' Records?

A15: **If you are sending everyone in for subsidy, then no. Remember that there are more data elements required for a complete 'D' transaction, so if you don't want to send separate 'D' records when people are rejected because of subsidy, then you need to include that additional data with your 'S' records in the first place.**

Q16: We do not use a PCN for electronic routing of drug claims. What happens if we do not enter a PCN?

A16: **All drug payers that process claims electronically have an RxBIN, but not all use, or need to use, a PCN. The only two Rx-specific identifiers that are always required when reporting a network pharmacy benefit, indicated by coverage type U, W, X or Y, are the RxBIN and Rx Insured ID Numbers. Please include all other Rx-specific information on the record that your drug plan uses to pay claims so that benefits can be efficiently coordinated.**

RETIREE DRUG SUBSIDY (RDS) INFORMATION

NOTE: Questions in this section generally address issues regarding the RDS file submission process using a VDSA. Questions that are specific to the requirements of the RDS program should be directed to the RDS Center, at **http://rds.cms.hhs.gov.**

Q1: If we use the Non-MSP file to submit 'S' records that will be passed to RDS for processing, will we have to submit 'N' records to receive Medicare entitlement data?

A1: **No. All record types submitted on either the MSP File or Non-MSP file will be returned with Medicare entitlement data. This is an advantage to using the VDSA process to submit enrollment files to the RDS Center rather than using the RDS Center's Web portal. When processed through the VDSA process the response from RDS provides the VDSA partner with Parts A, B and D Medicare entitlement data, while responses directly from the RDS Center's Web portal do not.**

Q2: Section D.2. states that for "S" records submitted on the Non-MSP Input File that "If the Non-MSP Covered Individuals submitted by the Employer are found by CMS to be enrolled in Medicare Part D, CMS shall convert the records of those individuals into secondary prescription drug coverage reporting - D Records." What happens if we don't include all of the data elements required to build a ‘D’ record?

A2: **In addition to receiving an ‘S’ disposition code of ‘04’ in Field 29 (S Disposition Code) of the Non-MSP Response File stating that the beneficiary is already enrolled in Part D, you will receive a ‘D’ disposition code in Field 48 (D/N Disposition Code) and at least one Error Code denoting the reason for the rejected ‘D’ record.**

Q3: If an ‘S’ record is rejected for subsidy because the individual has enrolled in Part D and we get him/her to immediately disenroll from Part D, can we resubmit the individual on the next file as an ‘S’ record?

A3: **Yes. However, we do expect you to submit a ‘D’ record reporting drug coverage that was secondary while the individual was enrolled in Part D. If a ‘D’ record had already been successfully created when the individual was rejected by RDS for Part D entitlement, then you would need to submit an Update record (Transaction Type 2) with a Termination date being equal to the day the beneficiary disenrolled in Part D. If a ‘D’ record had not been previously accepted by the COBC, please submit the ‘D’ record as an Add record (Transaction Type 0).**

Q4: Is it really necessary for us to send a separate file containing "Drug" (Action Type 'D') records when we will be sending the data for those who are enrolled in Part D on our 'S' Records?

A4: **If you are sending everyone in for subsidy, then no. Remember that there are more data elements required for a complete ‘D’ transaction, so if you don't want to send separate ‘D’ records when people are rejected because of subsidy, then you need to include that additional data with your ‘S’ records in the first place.**

Q5: We have a customer who has chosen to take the Retiree Drug Subsidy for 2006. They will be filing two separate applications for the RDS for the two separate plans. If the customer decides to use the VDSA for the retiree list submission, how can the two groups be identified? Within the response file that is provided, can it be determined under which RDS application each retiree is being submitted?

A5: **The RDS files will be submitted by RDS ID in the header. So if an employer has 100 members in each of two groups, they get two RDS IDS. All 100 of**

each group would be submitted in separate files identified by the unique RDS number in the header record. RDS will pass back, through the VDSA process, each file of 100 response records as they complete processing.

Q6: In using a quarterly VDSA feed, will the employer be entitled to subsidy payments monthly or will quarterly be the most frequent payment option?

A6: **We will now be able to accept the non-MSP feed, which is the file that contains the subsidy records, on a monthly basis. Please refer to the RDS for payment options.**

Q7: What was the deadline for signing the revised VDSA in order to use the VDSA submission method to qualify for the RDS? Can we rely on the existing VDSA for this purpose if the revised VDSA is in process?

A7: **Subsidy files for Plan years beginning January 1, 2006 had to be submitted by September 30, 2005. To pass data to RDS, you need to have a signed VDSA before CMS can accept the file via the VDSA procedure. New agreements were first released in final form in August 2005.**

Q8: Starting in September, we will send the first full Retiree List file (skeleton file), to which we expect to receive a VDSA response file. Additionally, should we expect to receive a Monthly Unsolicited Response File from RDS via the VDSA Non-MSP Response Process/Format? Is our understanding of this new process correct?

A8: **Yes. We have to offer the same service as RDS if we want people to use a VDSA. Since RDS will be sending unsolicited responses, we will too.**

Q9: Will the unsolicited response come to us only in the VDSA quarterly file process, or could we receive miscellaneous monthly response files when the RDS Start or End Dates are changed.

A9: **We are planning to send the unsolicited responses out on a monthly basis even if your normal VDSA submissions are quarterly. Plan sponsors sending in their retiree files via VDSA will get the unsolicited notifications. You will get these notices through the VDSA process using the same response file format as in the retiree responses that were "solicited." We will use the reason codes to indicate what has changed. An email will be sent to your account manager (and any other designees) with permissions for file transfer on your RDS application when the notification files are sent. The notification files are the only source - we will not be showing the actual notifications on the Web site.**

Q10: **Scenario**

1. Ford Retiree John Doe is included on our first VDSA September Eligibility file of members whom we believe could be Qualified Covered Retirees. The effective date on his record is 01-01-2006.

2. RDS accepts his record and sends a VDSA response record with an "accepted" S-Disposition Code and an RDS Start Date of 01-01-2006.

3. John doesn't read any of the outreach communications that Ford has sent to its retirees...he applies for Part D.

4. Because there is an accepted Plan Sponsor Record for John in the MBD/RDS System, he is rejected for Part D and notified to contact his former Employer regarding his Drug coverage through their plan.

5. RDS sends an e-mail notification to Ford of John's application and also posts an "alert" to the RDS Web site.

6. Ford has a follow-up outreach plan.

7. John insists that it is his right as an American Citizen to enroll in Part D and he does so.

8. RDS will receive an "alert" from the MBD that John has enrolled in Part D and will populate an "RDS Termination Date" on his record.

9. Ford has not sent any additional records for John to RDS because nothing has "changed" on the Ford end and they don't know, yet, that he has enrolled in D. RDS will automatically send this unsolicited "changed" record to Ford.

10. After RDS has "accepted" John's initial Subsidy Record and there are no Changes on the Ford end to his Subsidy record, Ford continues to send John's record in the Non-MSP File as an "N" record in order to learn of any changes to his Medicare Entitlement. Ford receives a VDSA response to the "N" record indicating that John has a Part D Start Date.

Question based on scenario above:

If Ford sends a "change/update" record to RDS and populates the "Termination Date" for a record that RDS has already closed on their end, will the RDS response to this Update Record be an "Accepted" Disposition Code - indicating that they accept our Change (Term Date) - and also will they populate the RDS End Date? Or...will the RDS Response to this Update

Record be a "reject" Disposition Code with a Reason of: "Enrolled in Part D" - and if so, will RDS populate the RDS End Date on this reject record?

A10: **You will receive notification directly from the RDS Center that the retiree tried to enroll in Part D and was initially rejected. You will also receive the notification from the RDS Center when the retiree overrides the initial rejection and signs up for Part D. That notification record will have the subsidy dates adjusted to show a termination date as applicable or an indication that they are now rejected for the subsidy entirely. You do not need to send RDS an update record with termination dates. Simply take the notification we send and update your internal files accordingly. However, if you do send a delete or an update, RDS will process it. As long as the dates you submit fall outside the Part D eligibility dates, we will accept your subsidy period as submitted. But if there is an overlap, we will correct the subsidy dates and send them on the response record. If there is no time period for which you can claim the subsidy we will send back that information in the response.**

Q11: For 2006, we are planning to continue to offer medical coverage to our post 65 retirees and will be applying for the 28% subsidy. In doing so, we will need to supply claims data to CMS. Do you have information regarding the data requirements that will be needed for this task?

A11: **Please visit http://rds.cms.hhs.gov/ for more information regarding submission of subsidy claims data. The Coordination of Benefits contractor is not the same entity as the Retiree Drug Subsidy contractor, but will be working with the RDS Contractor to pass enrollment information to RDS via the VDSA process.**

Q12: The CMS is always saying that if a beneficiary signs up for Part D, then shows up on an employer roster, that CMS will notify the employer. This seems to be a coordination of benefits process. So is that happening in a way not connected to the RDS feed? Isn't that basically a COB? Would that not happen without VDSA? Can you speak to that? Must an employer undertake a VDSA to have that level of feedback and reconciliation?

A12: **Everything that RDS offers is available to an employer whether they report enrollment information to RDS directly or via the VDSA. All employers claiming the subsidy will be notified by the RDS Contractor via email when someone enrolls in Part D. One of the additional benefits of the VDSA is that it allows for a query of Parts A, B, and D entitlement information between submissions using our dial up application called BASIS. RDS will not give you that kind of detail.**

Future enhancements to the COB process will include the ability to inform the VDSA partner when someone else (another insurer, employer, attorney,

beneficiary, etc) submits coverage information regarding the records submitted by the VDSA partner.

Q13: When will the new VDSA agreement be available and when can new employers start submitting information for the RDS?

A13: **We began sending out new agreements along with the corresponding record layouts and business rules in early August, 2005. Full implementation will begin November 15. Employers may use the VDSA process to start submitting files to the RDS Center now. If you would like to receive more information about the VDSA process you can contact cobva@ghimedicare.com to have your name added to our distribution list.**

Q14: We are an insurer who will soon be offering to submit Enrollment files to the RDS Center on behalf of many of our plan sponsors (employers). Although we won't be able to submit their files on their behalf for a short time, should plan sponsors still check the VDSA block on their application or should they check whatever method is being utilized for submission of the original retiree list and then modify the information later?

A14: **Plan sponsors should check what method they will use initially, and then modify the application later when their insurer is ready to submit enrollment files on their behalf.**

Q15: Can you please confirm that the payment request information can not be sent via the VDSA, so plan sponsors will still need to select another method for transmitting this information (file upload to secure Web site or mainframe to mainframe transfer), even if their enrollment updates are submitted via the VDSA?

A15: **Yes. The VDSA process can only be used to submit monthly or quarterly enrollment files to the RDS Center. All other data, such as the initial application and payment information must be exchanged through the RDS Center's Web portal.**

Q16: If I can only submit enrollment files to the RDS Center via the VDSA and will still have to submit other information to the RDS Center via their Web portal, why should I use the VDSA process?

A16: **The VDSA process allows for complete and timely coordination of benefits with for all members of your health plans, working or retired. Through a mutual exchange of health plan coverage data for Medicare entitlement information, claims are processed correctly the first time, thus eliminating many of the administrative expenses associated with dispute resolution and follow-up. Enrollment files submitted to the RDS Center via the VDSA**

process are returned to the submitter with valuable Medicare Parts A, B and D entitlement data that the RDS Center cannot provide via its Web portal.

Q17: What are the definitions of the RDS Start Date and RDS End Date fields in the Non-MSP Response File?

A17: **These dates define the time period during which the RDS Center determines the partner can claim the subsidy.**

Q18: What are the benefits of submitting the Non-MSP file every 30 days? Every 90 days?

A18: **This is a business decision that each partner will have to evaluate and make on its own. Many entities that will be using the VDSA to submit enrollment files to the RDS Contractor wish to submit on a monthly basis so that they can receive RDS payments on a monthly basis. Others may want to receive Medicare entitlement data on a more frequent basis and will submit Non-MSP files on a monthly basis. Conversely, other VDSA partners want to have more time to evaluate the response files and more time to build their next submission files and will choose to submit Non-MSP files on a quarterly basis. They are concerned that the extra resources needed to perform a monthly exchange will make it cost prohibitive or worry that in rushing to meet a monthly deadline, they would more likely submit erroneous or incomplete data.**

Q19: The "Description" for Field 14 of the Non-MSP Input file – Rx Group Number – states that this field is required with action type 'S' when coverage type = U, W, X, or Y. What if we don't use an Rx Group Number?

A19: **The RDS Center requires this field, and has instructed employers to make up a number for this field, if necessary, to allow the record to process at the RDS Center. Please contact the RDS Center for additional information.**

Q20: If we decide to submit our Non-MSP files on a quarterly basis and we are submitting 'S' records for the subsidy, can we still request Subsidy Payment on a monthly basis?

A20: **Yes. And you should direct this and similar questions on the subsidy payment process directly to the RDS Center.**

Q21: If we receive an 'S' Disposition Code indicating that the beneficiary is not entitled to Medicare, does this mean that RDS found the beneficiary in the Medicare Beneficiary Database (MBD), but that they are not currently entitled, as opposed to the reason "Beneficiary Record not found"?

A21: **"Not Entitled" means the retiree was found on the MBD but was not entitled to Medicare benefits during the coverage period. "Not Found" means the retiree could not be found on the MBD at all.**

Q22: Please provide internet resources I can go to for more information about the Retiree Drug Subsidy program.

A22: **The RDS Center has a web site at:**

http://rds.cms.hhs.gov/

This is the primary internet address for the RDS Center.

V: 12/01/05